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Dr. Petit
area V
USC

California Committee Regional Medical Programs

ASILOMAR CONFERENCE

OCTOBER 28-30, 1970 PROCEEDINGS

NEIL C. ANDREWS, M.D.
General Chairman

CHARLES H. WHITE, Ph.D.
Proceedings Editor

CALIFORNIA REGIONAL MEDICAL PROGRAMS REGIONWIDE CONFERENCE

ASILOMAR CONFERENCE GROUNDS

October 28, 29, 30, 1970

Wednesday, October 28

4:00 - 6:00 p.m.	Registration	
6:00 - 7:00 p.m.	Dinner	
7:30 - 9:00 p.m.	Orientation - Neil C. Andrews, M.D.	
	Presentations of Area Activities - Merrill Hall	
	Area I	Cancer Program Sam Sherman, M.D.
	Area VI	Perinatal Monitoring Richard Walden, M.D.
	Area VIII	Stroke Volunteer Program Mrs. Emily Hackler, R.N.
9:00 -	Meeting of Workshop Chairmen at Podium immediately after presentations	

Thursday, October 29

7:00 - 8:00 a.m.	Breakfast	
8:30 - 9:00 a.m.	HSMHA and Health Care - Vernon Wilson, M.D.	
9:00 - 9:20 a.m.	Area III	Multiphasic Screening Jeanne LeBrun
9:20 - 9:40 a.m.	Area II	RMP - CHP "B" Relationship Charles White, Ph.D.
9:40 - 10:00 a.m.	Area IV	Northeast Valley Project Barton Fischer, M.D. - Louis Garcia
10:00 - 10:20 a.m.	Coffee Break	
10:20 - 10:40 a.m.	Area V	East Los Angeles Cares and Concerns Frank Aguilera, M.P.H.
10:40 - 11:00 a.m.	Area VII	Physician Continuing Education Through a Resident Physician Sabbatical Exchange Marion Mykytew, M.D.
11:00 - 11:20 a.m.	Area IX	The Use of a Community Task Force in Planning a School of Allied Health Charles Buggs, Ph.D.
11:20 - 12:30 p.m.	Lunch	
2:00 - 3:20 p.m.	Workshops	
3:20 - 3:40 p.m.	Coffee Break	
3:40 - 5:00 p.m.	Workshops	
6:00 - 7:00 p.m.	Dinner	
7:30 - 9:00 p.m.	Workshops	

WORKSHOP SCHEDULES

1. Area-Region Relationships	William A. Markey
2. Category Disease Planning vs. Comprehensive Medical Care Planning	Sam Sherman, M.D.
3. Regional Medical Programs and Health Manpower Education	Richard T. Walden, M.D.
4. Regional Medical Programs - Comprehensive Health Planning	Michael Shimkin, M.D.
5. The Committee	Charles White, Ph.D.
6. Regional Medical Programs and Voluntary Health Agencies and Other Non-Federal Agencies	William Fowkes, M.D.
7. Core Staff Structure and Function	Al Torribio
8. Regional Medical Programs and Medical Schools	Jane Malmgreen John Stroessler, Ed.D.

WORKSHOP ASSIGNMENTS

GROUP	MEETING ROOM	2:00-3:20 p.m.	3:40-5:00 p.m.	7:30-9:00 p.m.
A	Scripps Patio	(1) Markey	(8) Stroessler	(7) Torribio
B	Scripps Lounge	(2) Sherman	(1) Markey	(8) Stroessler
C	The Lodge	(3) Walden	(2) Sherman	(1) Markey
D	Marlin	(4) Shimkin	(3) Walden	(2) Sherman
E	Viewpoint	(5) White	(4) Shimkin	(3) Walden
F	Merrill	(6) Fowkes	(5) White	(4) Shimkin
G	Tide Inn	(7) Torribio	(6) Fowkes	(5) White
H	The Dolphin	(8) Stroessler	(7) Torribio	(6) Fowkes

Friday, October 30

7:00 - 8:00 a.m.	Breakfast
8:30 - 9:30 a.m.	Workshop Reports
9:30 - 10:30 a.m.	Discussion
10:30 - 10:45 a.m.	Mack Smith, M.D., Regional Health Director
10:45 - 11:30 a.m.	Paul Ward

WORKSHOP PARTICIPANT ASSIGNMENTS

GROUP A (Scripps Patio)

Area-Region Relationships - Markey
RMP & Medical School - Malmgreen/ Stroessler
Core Staff - Torribio

Max Miller, M.D. - IV
Mitchell Covel, M.D. -IV
Mrs. Jean Ralph - VII
Marcy Braiker - I
Mrs. Jack Dohrmann - I
Marge Heafey - I
Wilfred Lee - I
Frank Jones - II
La Verne Westerlund - III
Marge Crump - V
Wilson Mizener, M.D. - V
John S. Lawrence, M.D. - VI
Emily Kander - VI
Bert Tesman, M.D. - VIII
Mrs. Catherine Germany - IX
Mrs. Betty Frazier - IX
Robert A. Brook - CHP
Mrs. Virginia Greer - I

GROUP C (The Lodge)

RMP & Health Manpower Education - Walden
Categorical Disease Planning vs. Comp. Medical Care Planning - Sherman
Area-Region Relationships - Markey

Sheila Cadman - IV
Marion Mykytew, M.D. - VII
Keith MacGaffey, M.D. - VII
Dr. Gerald Shaw - IV
Dr. Marcella Davis - I
James Von Tellrop - I
Henry Dishroom - I
Joanne Reed - II
Helen Blood - III
Mrs. Carlee Spencer - III
James Knight - IV
Clyde Madden- V
Lee Cady, M.D. - V
Lois Friss - VI
Valarie Vance, Ph.D. - VIII
Mrs. Patsy Kelson - IX
Mrs. Florence Wyckoff - CCRMP
John V. Naish - CCRMP
Charles K. Guttas, M.D. - II

GROUP B (Scripps Lounge)

Category Disease Planning vs.
Comp. Medical Care Planning - Sherman
Area-Region - Markey
RMP & Medical School - Malmgreen/Stroessler

Satoshi Hayashi - IV
George Packard, M.D. - IV
Dr. David Miller - VII
Dr. Leslie Gaelen - VII
Dr. Melvin Scheinman - I
Judy Schuknecht - I
Maurice Dawson - I
Joseph Cosentino, M.D. - II
Jeanne LeBrun - III
Lorraine Brown - III
Grace Carpenter - IV
John Lloyd, Ph.D. - V
William Monroe - VI
Claire Adams, R.N. - VIII
William Green - IX
Alfred Haynes, M.D. - IX
Mrs. Pat Alexander - IX
Elma Plappert - TARDAC

GROUP D (Marlin)

RMP - CHP - Shimkin
RMP & Health Education Manpower - Walden
Categorical Disease Planning vs.
Comp. Medical Care Planning - Sherman

Marlene Checel - V
William Schmalhorst, M.D. - IV
Dan Sullivan - IV
Paula Liska - VII
Alice Johnson, R.N. - VII
Mrs. Florence Stroud - I
Sandra Halldorson - I
Brian Dobrow - II
Virgil Gianelli, M.D. - III
John Simmons, Ph.D. - IV
Dorothy Anderson - V
Mrs. Celia Mittleman - V
Edwin McGhee - VI
Harry Hunt - IX
Mrs. Marion Grindell - IX
Lyndall Birkbeck
Gregory Lewis

GROUP E (Viewpoint)

The Committee - White
RMP - CHP - Shimkin
RMP & Health Manpower Education - Walden

Nat Feder - IV
Jack Cheever - VII
Helen Randall - VII
James Rogers - I
Juanita Stone - I
Mrs. Josephine Williams - I
Mrs. Jean Filer - II
Herbert Bauer, M.D. - II
Thomas Elliott, M.D. - III
Mrs. Ruth Kaiser - III
V. M. Farrell - IV
Louis Garcia - IV
Kay Fuller - V
Miss Pat Spartnicht - V
Paul White - VIII
Mariano Contreras - IX
Ronald S. Currie - RMPS Rep. HEW
Jack Long - State Health

GROUP G (Tide Inn)

Core Staff - Torribio
RMP & Voluntary Health Agencies
& Other Non-Federal Agencies - Fowkes
The Committee - White

Lee Horovitz - IV
Derek Price - VII
Eileen Innis - VII
Marjan van Overbeek - I
Mr. Lardja Sanwogou - I
George Lowrey, M.D. - II
Stanley G. Parry - III
Phyllis Hall - III
Mrs. Juanita Dudley - IV
Jane Z. Cohen - V
John Traband - VIII
Marcelina Kalmbach - VIII
Mrs. Lillian Mobley - IX
Miss Carolyn Phillips - IX
Gary Affolter - VI
Liz Bernheimer - I
Al Parham - I

GROUP F (Merrill)

RMP & Voluntary Health Agencies
& Other Non-Federal Agencies - Fowkes
RMP - CHP - Shimkin
RMP & Health Manpower Education - Walden

James Ricketts - IV
Frank Forbes - VII
Donald Sherman - VII
Dennis McGee - VII
Marilyn Griffin - I
Mrs. Elizabeth Oakley - I
Dorothy Dunning - II
Frank Harland - II
Clifford Carpenter - III
Jackie Reinhardt - IV
Nils Bolduan, M.D. - IV
Frank Aguilera - V
Mrs. Loris G. Phillips - V
Mary Jane Bromley - VIII
Erline Williams - IX
John White - State Health
Bob Porter - State Health
Martin Schickman, M.D. - IX

GROUP H (The Dolphin)

RMP & Medical School - Malmgreen/Stroessler
Core Staff - Torribio
RMP & Voluntary Health Agencies
& Other Non-Federal Agencies - Fowkes

Walter Graf, M.D. - IV
Mrs. Elaine Bogan - VII
Miss Audrey Massey - I
Joseph Calamusa - I
Rev. Cyrus S. Keller, Sr. - II
John Beljan, M.D. - II
Mrs. Mary Alderson - III
Miss Eleanor Stittich - IV
Elsie McGuff - V
Leon C. Hauck - V
John Conner - V
Diane Affolter - VI
Sue Ungermann - VIII
Mrs. Edris Burroughs - VIII
Dr. Harris Peck - IX
Charles W. Buggs, Ph.D. - IX
Edna Chapman - CCRMP
Mrs. Caffie Green - IX

GREETINGS

Neil C. Andrews, M. D., Chairman

Welcome to Asilomar and to the Regionwide Conference of California Regional Medical Programs. This is really a birthday party for RMP and Public Law 89-239 -- They are five years old this month of October.

This meeting grew out of a suggestion in March of this year by Don Petit of Area V. He had observed that all Areas of the California Regional Medical Program had established a variety of activities which needed to be displayed to other interested parties.

Secondly, he observed that there is a vast array of people working with Regional Medical Programs on various operational activities who are not visible outside their Area or perhaps not even outside the project itself.

It seemed appropriate to discuss the possibility of a Regionwide Meeting, therefore, of one or two days duration at which time we could present in a scholarly fashion the productive activities that are now going on within California.

As a result of this suggestion which was presented at the April Meeting of the Staff Consultants, a Planning Committee was formed. At their first meeting on May 21st, this group quite logically raised the questions why, what for, when, and how of a statewide California Regional Medical Program Meeting. The Committee was able to agree that there was a need for such a meeting and that it would be wise to talk about some of the new directions of the Regional Medical Programs and to have a discussion between the staff and the Area Advisory Groups about activities that have been accomplished in the past and are now ongoing at this time. A title was suggested which was California Regional Medical Programs Past, Present, and Future. Another title suggested was RMP-Expo, but that didn't survive. The original notion that this Conference should be relatively formal and should consist of a number of brief scientific papers solicited from each Area was soon discarded by the Committee who felt that such an approach represented more nearly a scientific society approach which would not allow enough appropriate interpersonal communications among staff and volunteers of RMP.

The eventual result, as you can see from the program for the next day and a half is a combination of techniques beginning with the presentation from each Area of the description of an ongoing project. We hope the Area presentations will enable those of us attending this conference to have greater insight into the actual happenings within the California Region. The meat of the program, however, will be the workshops. These will take place on Thursday afternoon and evening and are ably chaired by representatives from each Area. It is the hope of the Planning Committee that each of those subjects explored in a workshop will be discussed thoroughly from all points of view so that the chairman can bring a true summary of those discussions to the Friday morning report period. Thus the thoughts, insights and conclusions of all eight workshops can be made known to the total conference and perhaps provide focus and direction for our future activities.

We are most fortunate to have with us during this session, Mr. Paul Ward, the Executive Director of the California Regional Medical Programs, and Dr. Vernon Wilson, the Director of Health Services and Mental Health Administration of the Department of Health, Education and Welfare. Dr. Harold Margulies, who is Acting Director of the Regional Medical Programs Service, regrets that he will be unable to be here as originally planned. These able men will be most helpful by providing input from Administrative and Legislative attitudes towards Regional Medical Programs. I sincerely hope that the next few days are busy and fruitful, that they add to your understanding and stimulate your interest in the Regional Medical Programs. Further, I trust this is not all work, but that during your stay here you will enjoy the beautiful scenery and have fun, but don't skip the workshops.

AREA I REGIONAL CANCER PROGRAM

SAM SHERMAN, M.D.

I. GENESIS OF THE PROGRAM

As recognized in the creation of the Regional Medical Program for heart disease, cancer and stroke, cancer is one of the major diseases causing morbidity and death among the population of the United States. While loss of life from infectious diseases has lessened, the incidence of the degenerative diseases and cancer has increased. Cancer afflicts approximately 330 people per 100,000 population per year. The death rate is approximately 200 per 100,000 per year, which is almost 20% of all deaths. Based on the population of Area I, it would be expected that an area containing about 4.5 million persons would produce a total of 15,000 cancer cases per year.

Because cancer represents a broad spectrum of diseases originating in a wide variety of sites from a number of histologic structures, treatment is complex. The proper management of cancer patients requires not only one but multiple, highly trained and experienced specialists working in close cooperation. Comprehensive medical care of the cancer patient in Area I of Northern California is further complicated by the great distances between medical facilities, the population concentration varying from the metropolitan San Francisco Bay Area to the small North Coast communities, and a shortage of physicians and para-medical specialty skills.

At least 50% of cancer patients require radiation therapy at some time during their management; probably 50% require chemotherapy, and an equal number, surgery. Although the supply of general surgeons in the Area was reasonably adequate, there was only a small number of surgeons who specialize in, or devote a majority of their practice to cancer surgery. Further, it was estimated that there were less than 20 fully-trained, practicing chemotherapists and only 15 trained full-time radiation therapists in Area I. It was estimated that approximately 50 chemotherapists and 50 radiotherapists would be required for optimum care. In addition to the limited personnel, the necessary physical facilities in this Area were also insufficient; for example, in radiation therapy and there were only 11 supervoltage and megavoltage radiation therapy units, yet the need has been estimated to be at least 42 such units.

Within Area I, two medical facilities, the University of California Hospital and Medical Center; and Mount Zion Hospital and Medical Center, an associate hospital of the University of California, possessed broad-based oncology programs. The University of California Hospital and Medical Center and the Zellerbach Saroni Tumor Institute of Mount Zion Hospital and Medical Center, while geographically and administratively separate, have previously cooperated in joint programs in cancer education and research. Their programs in cancer education, research and patient care, including but not limited to radiation therapy, chemotherapy, and surgery, were being offered to several peripheral institutions. These two centers therefore agreed to be involved in a regional cancer program to utilize existing resources, personnel, equipment, and expertise to the maximum extent possible, and to permit extension of their present services to additional peripheral medical groups. It was recognized that other medical centers and groups in this region also possessed excellent resources and it was expected that those who wish will be incorporated into the program as the details can be worked out.

A climate of cooperation exists between the two named institutions. Joint appointments of the Mount Zion Hospital and the University of California clinical radiotherapy, physics and radiobiology research staffs existed. Only these two institutions, in Area I, possessed a full range of ongoing programs and functioning resources, including radiation therapy personnel, straight radiation therapy training programs and trainees, radiation physics, and radiobiological staffs. The objectives of the program are to provide an in-depth oncologic service to peripheral facilities, to incorporate into the program the professional personnel currently supplying services to these areas, and to supplement the peripheral facilities wherever necessary with the more complete resources of the University of California and Mount Zion. This proposal was in response to an increasing demand to broaden the scope and increase the depth of the service already being provided on a small scale. As other institutions in the region are able to contribute to the program and can be assimilated, they will be encouraged to participate.

II. PROGRAM DEVELOPMENT

That physicians practicing in the cancer field have certain unmet needs became apparent through: 1) existing bilateral consultation and cancer care programs, 2) personal contact between

members of the staffs of the University of California Medical Center, San Francisco (UCSF), the Zellerbach Saroni Tumor Institute of Mount Zion Hospital and Medical Center (ZSTI) and other hospitals, and 3) multiple refresher courses given by the University's Division of Continuing Education. Because of these general observations and in order to evaluate specific local requirements, the planning staff of the Area I Regional Medical Program involved itself extensively in conversations with physicians in communities in the Northwestern part of California and in surrounding areas. Many portions of the program to be offered were suggested by prospective participants. The RMP planning staff and members of the cancer teams at UCSF and ZSTI actually contacted representatives and/or members of the medical staffs of the following California Hospitals:

Alta Bates Hospital, Berkeley
Brookside Hospital, San Pablo
Children's Hospital and Adult Medical Center, San Francisco
Concord Community Hospital, Concord
Contra Costa County Hospital, Martinez
Eden Hospital, Castro Valley
Franklin Hospital, San Francisco
Fresno Community Hospital, Fresno
Harkness Memorial Hospital, San Francisco
Highland Hospital, Okaland
Kaiser Permanente Hospital,Oakland
Kaiser Permanente Hospital, San Francisco
Marin General Hospital, San Rafael
Merritt Hospital, Oakland
Peninsula Hospital, Burlingame
Queen of the Valley Hospital, Napa
St. Joseph's Hospital, Eureka
St. Francis Memorial Hospital, San Francisco
Santa Rosa Memorial Hospital, Santa Rosa
San Francisco General Hospital, San Francisco
Sonoma Valley Hospital, Sonoma
U. S. Naval Hospital, Oakland
U. S. Public Health Service Hospital, San Francisco
Veterans Administration Hospital, San Francisco
Veterans Administration Hospital, Martinez

Through these discussions, it became evident that many of the hospitals in the Area have problems in cancer management which could be helped by a consultation and planning service. Some medical groups had definite strength in certain areas such as cancer surgery, chemotherapy or radiation therapy, but few had strong representation in all fields of cancer management. It seemed that a cooperative arrangement, in which the talents of all hospitals could be used to aid and strengthen those lacking certain aspects of knowledge or equipment, would be of value.

III. RESOURCES AND PRESENT ACTIVITIES

A. Resources

The resources and programs of the University of California, San Francisco Medical Center and Mount Zion Hospital and Medical Center are extensive. Both medical centers are equipped with the latest diagnostic and therapeutic equipment and both have active teaching programs in all aspects of medical care. According to the California Tumor Registry, approximately 3500 new cancer patients are seen per year in these institutions. Of these, it is estimated that 1600 patients per year are seen by the radiation therapy departments of the two institutions.

1. University of California Hospital and Medical Center

The UCSF Medical Center has been serving for years as a regional educational and referral facility. In the Radiotherapy Department approximately 75% of patients treated are from outside of San Francisco County; they are derived from all counties within the northern two-thirds of the state as well as from Oregon and Nevada. Informal consultative arrangements exist with physicians within all counties of the northern part of the state. The chemotherapy, medical and various surgical specialty clinics have similar long standing consultative arrangements with the physicians of Northern California and adjacent areas. Within the institution are numerous multidisciplinary cancer clinics (Visible Tumor Clinic, Consultative Tumor Board, Gynecology Tumor Clinic, Head and Neck Tumor Clinic, Otolaryngology-Radiotherapy Clinic, etc.) some of which have been in operation for several decades and which serve to integrate cancer care at the institution.

The radiation therapy department of the University of California is a well established and widely known department, pioneering in supervoltage radiation therapy. It is equipped with or has on order, two supervoltage units, an orthovoltage unit, a radiotherapy simulator and a hyperbaric oxygen chamber. A megavoltage linear accelerator is ordered for delivery during the coming year. There is a full time radiotherapy staff of four qualified radiotherapists and three radiation physicists. The physics section has routine access to all the modern equipment which must be used in the operation of the regional program.

The chemotherapy service has a separate ward and out-patient clinic area under the auspices of the Cancer Research Institute. In addition, the CRI conducts the Consultative Tumor Board and extensive research activities in the field of cancer. There is a chemotherapy staff of four full time physicians.

The laboratory of Radiobiology is involved in cancer research activities and has a very diversified program in radiation biology, genetics and biochemistry. It has a staff of eight professional investigators plus supporting laboratories and personnel.

The Social Service Department has long been active in the management of cancer patients. Faculty of the School of Nursing have been engaged in teaching aspects of care of the patient with cancer.

2. Mount Zion Hospital and Medical Center

The Mount Zion Hospital is an acute general hospital of 450 beds, serving San Francisco, the Bay Area, and portions of rural California and neighboring states. The hospital has acquired a reputation as a center for education and research. There are fully accredited intern and residency training programs, and a well regarded post graduate course for general practitioners. There are a variety of lectures and visiting professorships scheduled throughout the year. Research in oncology, both at the basic and clinical levels is an important part of the hospital research program.

The hospital maintains extremely active oncologic services including surgery, chemotherapy and radiation therapy. There are approximately 1,000 cancer admissions yearly to Mount Zion Medical Center, and the Saroni Tumor Institute is presently treating approximately 8,000 new cancer patients yearly. Mount Zion Hospital and Medical Center participates in the State of California Tumor Registry, and keeps accurate records of all cancer patients.

In order to fill the need for a community cancer center, the Saroni Tumor Institute was established with the utilization of private funds matched by Federal and State funds under the Hill-Harris Plan. For maximum efficiency it was constructed as part of a general hospital to utilize the existing hospital beds, laboratory facilities, diagnostic x-ray facilities etc.

The Saroni Tumor Institute is 14,000 square feet in size. Space has been allotted for clinical practice, teaching, and research. A full time staff of 35 is headed by three radiation therapists, a specialist in nuclear medicine, two radiation physicists, a radiation biologist, and a social worker. The radiation therapists, the specialist in nuclear medicine, and one of the radiation physicists hold academic appointments in the Department of Radiology at the University of California Medical School. Similarly, members of the radiation therapy staff of the University of California serve, through joint appointments, as consultants at Mount Zion Hospital. Oncologic consultants in the various subspecialties who have been appointed to the Tumor Institute staff see patients on an individual basis as well as conduct regularly scheduled formal and informal patient conferences.

The radiotherapeutic equipment in the Tumor Institute includes: 25meV Betatron for production of electrons and x-rays, 6 MeV Linear Accelerator installed in 1968, Rotational Cobalt-60 Teletherapy Unit, Cesium-137 Teletherapy Unit 250 KV X-Ray Unit, Simulator, brachytherapy Sources (radium and strontium), hyperbaric Oxygen chamber (as an adjunct to radiation therapy).

The Tumor Institute is presently carrying out an approved four year residency training program in "straight" radiation therapy. Eight trainees are currently enrolled in the program. Residents in general radiology from Mount Zion Hospital, St. Mary's Hospital and Letterman Army Hospital receive training in radiotherapy at the Tumor Institute. This includes a three month course in the basic principles and clinical applications of nuclear medicine. Didactic lecture courses in oncology, radiation biology, radiation physics and nuclear medicine given by the Tumor Institute staff are attended by residents in radiology from training programs throughout the Bay Area.

IV. PROPOSED PROGRAM

The long range goal of the Regional Cancer program is to improve care for cancer patients. The more immediate program goal is to provide comprehensive, in-depth consultative and educational services in oncology that will supplement and improve existing resources in the area.

The basic philosophy of the program is to provide assistance to peripheral medical groups building on their existing strengths and resources, and then to aid these groups into an ultimate position of self sufficiency in cancer management. The program described here includes certain aspects of clinical oncology, data retrieval, and education; and it involves many of the hospitals in the area. As the program is further implemented, it is intended that both the scopes of the program and the number of participating hospitals will be expanded. Further, it is anticipated that as programs are developed in other aspects of cancer management they will be integrated with this program. For example, a program in chemotherapy designed to supplement and strengthen the chemotherapeutic aspects of this program was developed as a second phase to this grant application.

Overall policy in the implementation of the program is to be set by a Coordinating Committee. This Committee initially consisted of three representatives of the University of California, San Francisco Medical Center (Glenn E. Sheline, M.D., Ph.D., Theodore L. Phillips, M.D., B. Ralph Worsnop), three representatives of the Saroni Tumor Institute of Mount Zion Hospital and Medical Center (Jerome M. Vaeth, M.D., Jerold Green, M.D., Mary Louise Meurk), and one representative of Regional Medical Programs (Roy R. Deffebach, M.D.) The Program Coordinator is an ex-officio member without vote. This committee has assumed the following responsibilities: 1) insuring that the expenditure of funds for the program is in accordance with the stated budget; 2) insuring that program activities are carried out as stated in the grant application; 3) insuring coordination of activities and provisions of adequate service to all participating hospitals; 4) establishing policy for the operation of the program; 5) preparing periodic reports as required by Regional Medical Programs; and, 6) selecting the Program Coordinator. The composition of this committee changed during the implementation and future expansion of the Regional Cancer Program to allow for the integration of all aspects of cancer management and any supplements to this grant.

A Coordinator for the Regional Cancer Program, Samuel R. Sherman, M.D., was selected by the Coordinating Committee and assumed the responsibility of the daily administration of the program. He is an ex-officio member of the Committee and is responsible for the implementation of policy set by the Committee. His office is located within the local Regional Medical Program Office and he is a part of the RMP staff. He is specifically responsible for coordination of activities between hospitals and the development of adequate communications with them.

SUMMARY OF PROGRAM ACTIVITIES

In order to meet the needs of the patients of our Area with current resources, four major subprograms were proposed to enable more effective utilization and extension of the presently available resources. Other programs will be submitted as the needs are identified and resources become available. The first is the Clinical Cancer Consultation Service which provides consultant teams to participating hospitals. If a hospital does not feel that it requires a complete cancer management team, it will have the option of receiving aid from any particular specialist desired. These include radiation therapy, chemotherapy, surgery, nuclear medicine and social sciences. Physicians and paramedical consultants are available to attend local tumor boards on a biweekly or monthly basis and/or to attend clinics and treatment sessions in their specialties. Members of the Cancer Consultation team will also assist personnel at the participating hospitals to develop their own program, particularly programs in cancer chemotherapy and radiotherapy. The members of the team provide advice on the construction of facilities; architectural consultation will also be made available. The educational opportunities accessible to local personnel are stressed; these teams will actively attempt to attract prospective trainees to the ongoing preceptorship programs at the established cancer facilities.

The second portion of the program is a radiological physics service. This program assists the available radiotherapy resources to use their present equipment in an optimum fashion applying the modern radiotherapeutic techniques. Because of the extreme shortage of radiation physicists and equipment, it was evident that a regional effort would lead to a more rapid and adequate provision of these services. Certain installations cannot afford to employ a full time radiation physicist; this can be solved by the use of a regional program. In addition, the pooling of resources did enable the use of sophisticated computer techniques to solve many problems which previously required hours of laborious hand calculations.

The third program is a computerized data retrieval service. This system is provided to parti-

cipating hospitals on request and will serve as a memory bank of information about individual patients treated by means of radiotherapy, chemotherapy and surgery. It will be possible to put many informational items about each patient into computer tapes and on short notice to retrieve current information on the results of a given treatment technique in one hospital as compared to the region as a whole. This service will enable the individual hospital to evaluate its own performance in the cancer field. The data retrieval service will also act as an important part of the overall evaluation of this regional program. It is anticipated that both the data retrieval and the regional medical physics programs will serve to meet continuing needs for many years to come.

The fourth portion deals with an educational program for medical, paramedical and lay public. Educational aspects are, of course, included in each of the other three subprograms and it is probably within those portions of the program that the greatest opportunity for education occurs. With respect to training of radiotherapy technologists, a program has been organized with the City College of San Francisco. The initial year of didactic study will be at City College with the practical aspects being given at the University of California Medical Center and Mount Zion Hospital. The first class was opened in 1970.

It is hoped that one or two students graduating from the program each year will continue for two additional years during which they will be given credit courses at the Medical Center and will be qualified for a Bachelor's Degree.

The additional schooling will include detailed teaching of Physics and Dosimetry and will qualify these persons to become dosimetrists and chief technicians in Radiotherapy Departments. This type of person would then provide the major and most important link between the central physics service of the Regional Medical Program and the individual radiotherapy department.

CONCLUSION

The first major step in meeting a number of the California RMP objectives for cancer management is being accomplished in the first phase of the Regional Cancer Program that is now operational in Area I. This program has been well accepted and widely endorsed by communities throughout the entire Area. Phase I was developed through a cooperative arrangement between two medical facilities in Area I that have broad based oncology programs. These facilities, the University of California, San Francisco and Mount Zion Hospital and Medical Center, serve as the principal provider institutions for the program. This arrangement provides participating institutions with 1) clinical cancer consultation by medical specialists, 2) radiophysics consultation and treatment planning, 3) computerized data retrieval service, and 4) other specialized education services.

In addition, there was a defined need to develop further services in medical oncology and cancer chemotherapy, and to establish a nuclear medicine bank. The nuclear bank has just recently been approved by the Division of Regional Medical Programs, but not funded.

Phase II has been designed to supplement and enhance Phase I; the two will be integrated both functionally and administratively. Innovative educational aspects of the Phase II Program include its emphasis on local community chemotherapy clinics, model multidisciplinary team, informal telephone communications, and an individualized in-service tutorial program rather than conventional didactic programs. Cooperative arrangements between institutions and health professions have been developed to a high degree throughout the Area to ensure that the program can be implemented rapidly.

This proposal is an attempt to provide more comprehensive care to cancer patients and in the process to define gaps in services which indicate further program development.

Once Phase II becomes operational, the components of the program will no longer be described or though of in phases. They will rather be the necessarily interrelated activities of a single comprehensive program designed for optimal care of the cancer patient in his own community.

AUDIENCE QUESTION: What is being done by the Cancer Program to bring services to disadvantaged and ghetto areas in Area I?

DR. SHERMAN: The Cancer Program is educational in its thrust. No direct services per se are included in compliance with the original proposal's goals and objectives. These educational activities are centered in institutions and communities which have the facilities and resources to provide cancer management. Some of them are adjacent to disadvantaged areas and consequently render upgraded care to cancer patients of

DR. SHERMAN: of those areas.

If the Phase II Program becomes funded, additional and more comprehensive attention can be focused on the areas having high concentrations of poor and minority groups.

AREA VIII STROKE VOLUNTEER PROGRAM

MRS. EMILY HACKLER, R.N.

Area VIII of the California Regional Medical Programs has designed a pilot project for volunteer training in an attempt to provide a more comprehensive approach to meeting total health needs of the stroke patient. It has become apparent that volunteer services in the community could contribute positively to the continuity of care in rehabilitation and re-socialization of stroke victims. Under professional guidance and supervision this vast area of "hidden talent" may help to broaden the spectrum of stroke care.

The volunteer training program is aimed at the patient who has survived the stroke and will re-enter the community with a physical or communication disability. Upon discharge from an acute hospital a patient is sent either to an extended care facility, his own home, or on some occasions, to a board and care residence. It is our contention that this is a critical transition because the patient and family (if there is one) are confronted with the difficult task of readjusting to life with a disability. All too often, little consideration is given to the need for continuing rehabilitation and help with the patient's re-socialization; planning for the patient's future care is neglected either because the need for a supportive program is unrecognized or the service is unavailable. An aggressive rehabilitation program may help an individual regain or relearn tasks of daily living, but a continually stimulating environment over an extended period of time is essential if he is to maintain the level of activity with the realm of his physical abilities.

The volunteer, under professional and supervision, may be able to provide the patient's contact with the outside world as well as reinforce rehabilitation programs which have been tailored to meet the specific dimensions of his physical and communication handicaps. We believe that continued interaction with the volunteer, who is a member of the outside world, may help prevent regression of relearned skills in activities of daily living and help alleviate the feelings of isolation that the easily fatigued and often depressed patient experiences. In observing tensions of the immediate family, the patient is apt to sense that he has altered many living patterns of the persons for whom he has the highest regard. This basic concern, combined with the multitude of personal restrictions, very often results in a persistent desire for complete social withdrawal.

Our initial program will be geared toward the exploration of the needs of stroke victims with emphasis placed on stimulating their communication abilities and assisting them in re-socialization. The course will be conducted over a period of ten weeks and will consist of 40 hours of lecture on the causes and treatments of stroke. The students will observeregularly scheduled patient care conferences presented by the stroke team at the hospital in addition to field trips to rehabilitation centers and observations of speech retraining.

The pilot study will be conducted at St. Jude Hospital in Fullerton, one of the first institutions in Orange County to implement the concept of a stroke team. It has approximately 250 beds, with plans for an additional 80-bed rehabilitation unit scheduled to be completed in the early fall of 1970. The project has been given overwhelming endorsement by the hospital administration.

The Women's Auxiliary of the California Medical Association has voted to sponsor this program as their project of the year, Project Re-Entry. We shall draw volunteers from the Orange County branch of the Women's Auxiliary of the CMA, the Guild of St. Jude Hospital and interested members of the community. Many of these women are highly motivated, intelligent and dedicated people who have impressive backgrounds in community activities.

All patients who will be followed in the pilot project must be referred by their attending physicians. Periodic reports will be given to the physicians by the public health nurse coordinator. She also is responsible for supervising and evaluating the effectiveness of the volunteer placement. Of course, the patient and his family must consent to this type of follow-up before a volunteer assignment is made. The volunteers will be expected to coordinate their activities with other community agencies that are providing care to the patient, such as the Visiting Nurse Association or the Easter Seal Rehabilitation Center. The volunteer will be a visitor to the patient in the extended care facility or his home; she will be a driver when necessary; she will be a link with the community; but most important, she will be a friend. Hopefully, by mobilizing volunteers to provide services to the lonely, frightened and often-times aged members of our community we shall begin to meet some of the needs of the chronically ill population.

SIGNIFICANCE

As a result of the pilot project we hope to evaluate the effectiveness of the trained volunteer in meeting the long-term needs of the chronically ill individual. The volunteers will

function within the perimeters of care plans established by the health professionals and, hopefully, will be able to reinforce the rehabilitation program in the patient's home. She will be able to maintain an ongoing relationship with the family and patient, yet have consultation and supervision available from the public health nurse at all times.

We believe that the inclusion of the volunteer, as an informed and significant member of the health team, will demonstrate that her level of dependability, creativity and adaptability will increase commensurately with her assignment. Hence, from those who are capable of continuing assignments with chronically ill individuals and their families and can relate in a healthy manner to both patients and the professionals responsible for the planning and continuing assessment of patient care programs, we anticipate being able to develop a profile of volunteers most suited to responsible, long-term commitments.

In addition, we are hopeful that there will be not only a continuation of the service to the chronically ill in the community, but there will be an expansion of it throughout the county if this project demonstrates that stroke patients benefit from volunteer placement, and if the volunteers feel this type of responsibility is a reasonable assignment. The duty of coordinating and supervising the volunteer activities, logically, would be placed on a knowledgeable health professional in the community; she could be the home care coordinator in the acute care facility or a nurse in the local home care agency. At this time it appears that the person responsible for training and supervising the volunteers should be a nurse who has a strong rehabilitation background. The cost of such a program is nominal, in contrast to the vastly rich rewards one might anticipate for the strong patient.

AUDIENCE QUESTION: What is the age range of the stroke volunteer?

MRS. HACKLER: The volunteers range from ages 20 through middle 50.

AUDIENCE QUESTION: Is the volunteer program open to men?

MRS.HACKLER: Yes. I would like to include men on this program. However, at the present time, I do not have any male volunteers. (Mrs. Hackler mentioned that Dr. West, an orthopedic surgeon who has had a stroke, is quite interested in the volunteer program. He has addressed the volunteers.)

AUDIENCE QUESTION: Do you have any sounding of patient acceptance?

MRS. HACKLER: So far the patients and their families have accepted the volunteers well.

AUDIENCE QUESTION: How do you locate the patients?

MRS. HACKLER: Every time a stroke patient is admitted to a hospital the patient is attended by a stroke team for the purpose of therapy treatment at that particular hospital. The attending physician and/or the stroke team attendant refers these cases to me (Mrs. Hackler) for follow-up treatment by a volunteer worker.

DR. ANDREWS: We are very fortunate to have with us this morning Paul D. Ward, Executive Director, California Committee on Regional Medical Programs and Vernon Wilson, M.D., Director of Health Services and Mental Health Administration of the Department of Health, Education and Welfare. Mr. Ward will introduce Dr. Wilson.

PAUL WARD: Thank you Neil. It's a pleasure to introduce a very unusual gentlemen. When he was past the age of 35 he earned a BS, MS and MD in two years. Anybody who can do anything after the age of 35 is a great man. He graduated from the University of Illinois Medical School in 1950. Almost immediately upon graduation he received an appointment to the faculty as assistant professor and assistant dean. I don't know how he accomplished this and a set of guidelines should be written because I know a lot of students who would like to do the same thing. He became Dean of the University of Missouri Medical School in 1959; he served as Coordinator of the Missouri RMP; he left that position to become Vice-President for Health Affairs at the University of Missouri. His publications and writings have been essentially in the field of medical administration and I wish to add this comment about Dr. Wilson and his present position. He can have a great, great impact upon health care in the United States.

As you know, our own Rober Egeberg became Assistant Secretary for Health and Scientific Affairs. That position is essentially a policy position. We've often described it as a rather dangerous position and Roger knew it when he took it, because you sit up there virtually naked to the world. Sort of the focal point but with hardly any staff esentially to protect you. Vern's position is one which commands great resource strength in terms of highly trained, highly educated personnel which can put together programs and affect those programs because of their tremendous staff backing. I personally believe that Vern will do a tremendous job in this regard because I watched him build the Regional Medical Program in Missouri which did some fantastic things in terms of the kinds of programs he created. In spite of the politics of Missouri, he accomplished early in the game a great many advances. He knows the RMP backwards and forwards and it is my very great pleasure to introduce Dr. Vernon Wilson.

REMARKS

DR. VERNON WILSON

DIRECTOR

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

DR. WILSON: Thank you Paul and Neil. If I were as wise as you've just attributed me to be I probably would accept an introduction and sit down while I'm ahead. Perhaps one of the things we ought to clarify on the beginning is that I'm not really a public speaker. I am an individual who takes a great deal of interest and gets a great deal of pleasure as well as education out of meeting with groups like this. I would have preferred to discuss the kinds of things that will be presented here to you in seminar fashion so that you would have a fair and equal opportunity to respond. Constraints of time are not going to allow that so I begin simply by saying that if I speak with some degree of certainty on some of these points it's with a complete sense of humility knowing that if I had all of the available wisdom to bring to bear on these points what I'm about to say would surely have been modified somewhat. Nevertheless, there are some issues to which we must address ourselves with some clarity.

In the few minutes we have here it's my hope to place some of those issues into perspective; to give you some feeling of how we are progressing and to invite you as a collective group to respond to us in the national responsibilities we have. I'd like to talk for a few moments not in the negative sense, but in a realistic sense about the constraints under which planning in the health fields now must operate and this seems to me that constraints are not necessarily negative. I'm not one who believes in raising children that constraints are bad, I think they are a good point from which to start to work out a meaningful and coherent activity.

One of the constraints under which we operate is that most of the health money we receive is categorical in one nature or another. We start from the point of view that Congress has substantially an interest in voting money into the health field from a categorical point of view. Those of you who have worked with United funds know that communities also favor this kind of an approach. The second constraint that's probably most misunderstood at the moment is that there are some very real budgetary constraints and the approach of the Federal government to the handling of the budget for health has undergone some change in the last two or three years. Let me give you three

or four of these in rapid succession and if there's some of this you would like to discuss a little bit later I would be happy to provide additional insight into it. (1) of the $20 billion plus that's being spent for health in the national scene at the moment out of the Federal Budget, some $16 billion of that is in what are known as uncontrollable items. In this case, Medicare expenditures. Roughly $4 billion is spent in what is considered to be controllable - NIH, VA, Health Services and Mental Health Administration and this group of activities.

Now there is a new Federal approach to how one balances the books that Paul McCracken has described in newspaper releases. Some of you who have been reading with care recognize that there will not be deficient spending in the Federal government unless the gross national product is equivalent to that which would be expected if there was a 96% employment level. If under 96% they will deficient spend; if at 96% or possibily above there would be no deficient spending. Since there is no real intent to change the tax structure so far as any of us can perceive, since if you are in a deficient spending time you don't raise taxes and if you are in surplus time you don't need to raise taxes. The taxpayer, I think, gave a clue to this some time back and most of you have watched this phenomenon through the eyes of taxpayers. In the face in this somewhat stable relationship between gross national product and tax structure, health is still showing some slight increase in the percentage of expenditure, but this is not going to have the same kind of percentage increase in monies through controllable funds as it has had in the past. The third item I think that functions as constraint, and I'm leading really to the basis for the sort of planning we need to do together, is that there is still a rather sharp imbalance between the capacity of the health care system to make its services available and the demands. In fact, there are still enough resources coming in that our costs are going up in an economic response to the supply and demand phenomenon more than basic costs. Finally, in the list of constraints on planning, take into account that there are no real agreed upon national priorities by which you can start to talk about an orderly distribution of funds in the face of a shortage of potential funds.

Let me quote a few of these for you quickly. There is equity of access. Some people have greater access than others to the health care system which may be affected by geography in the rural areas or a number of other things including unwillingness of professionals to serve in a given area. There is the emphasis on age of children. There is an emphasis on disease categories, heart, stroke, cancer, and others. There's an emphasis on manpower addressed to the capacity. There's an emphasis on economic issues per se; OEO; there's an emphasis on social issues, drug abuse, and alcoholism and then there's an emphasis on ethnic issues; Indian Affairs. This is not an exhaustive list, but it gives you some idea of the various attacks that are being taken upon a system which has very few established priorities and it is rapidly becoming evident that if you do not have enough resources and you do not have comparable items against which you can make decisions that you either do not have a planned process or else you reorder the way in which you approach planning.

It is clear to me as I observe what's going on in the national scene, not only in Washington, but I think among groups across the country, that there is a growing agreement that equity of access, the ability to get into a health care setting, is rapidly becoming sort of the first order of priority and that right along with that goes a tremendous emphasis on one of the major blocks to equity of access which, of course, is the economic setting within which care takes place. Now if you turn to planning from an RMP point of view, and here I am volunteering to you my thinking and this is not a mandate in the sense that someone has decided, it rapidly becomes apparent that if in fact you have roughly $100 million a year in a nation which is spending $60 billion on the health care system and you wish to affect that system, a frontal attack on health care as such is probably going to net you relatively little. This says that if you are going to deploy these funds in a way that gives you a chance, you must continually introduce innovation into the system. You must be very careful that you do not fall into the trap that I think has engulfed some by trying to take on the direct care of health needs as such, or you will wind up without an ability to work with the system which so badly needs attention, and, I think, some reordering.

There are a few things I would like to leave with some of you who may not understand about Health Services and Mental Health Administration (HSMHA). This is the two minutes to be paid for having brought me out here. You know you've got to learn a little about my hobby too. There are 11 programs in that interesting organization, operating under 16 pieces of legislation at a level each year of about $1.6 billion. It operates in several thousand locations and there are a number of programs from different points of view that relate to it. It has a full range of health activities all the way from comment and sort of reporting , i.e., the National Clearinghouse for Smoking down to the Indian Health Service where we actually give virtually all of the health care. The list of groups that are in that constellation: National Institutes of Mental Health, including St. Elizabeth's Hospital: Maternal and Child Health, including Crippled Children's Service: National Center for Health Statistics; National Center for Health Services, Research, Development: Regional Medical Programs; Community Health Services with Comprehensive Health Planning including Migrant Health and OEO activities. Now as we are beginning to pick up some of those clinics, the Federal Health Services, including U.S. Public Health Service hospitals; Family planning; Center

for Disease Control in Atlanta; Indian Health Service; and the Hill-Burton.

It turns out that many of those acts have the same authorities in them and that, as a matter of fact, we have some internal planning to do of our own so I'm much interested in what you're doing here today from more than an academic point of view. I hope that you will understand as we begin to look at the various programs. We're interested in being sure that what we do is in fact in concert and is sufficent from the point of view of getting the most effect from your tax dollar.

Let me read one sentence from the announcement going into the Federal Registry saying "Regional Medical Programs serves as the focal point in health services and mental health administration for improving personal health care to development of the quality of performance by the providers of care placing special emphasis on continuing education of established professional health personnel and on cooperative arrangements among providers of care." That's not the whole description but for purposes of abbreviation I'll leave some of the other out. But I think that gives you some part of the context in which we work.

Let me address in a few minutes another issue with which you will be coming in contact and which I think bears on the issues of planning from your point of view and the future of RMP. We are very much involved in what has been called decentralization. It is a very much misunderstood process. As a matter of fact, you should like it and I hope you do. The only shift that is going on in decentralization which would, I think, be a possible source of concern, at least, as I've talked to RMP groups, really does not relate to any removal of perogatives in the RMP itself in the regions, but rather a transfer of responsibilities, from the national office to our regional offices of some of the authorities that we have posed at the national level. It is our intent, in fact, to go out of project by project review within the RMP's themselves and to give increasing responsibility to the local advisory group for making that kind of decision. We view our role at the national level as being increasingly that of reviewing whether or not your local decision making apparatus is fair, is equitable and that the general quality of the way in which you're attacking the national guidelines and the national goals that have been set out is, in fact, an effective one. We are, I think, in that process looking relatively intensively at the mechanisms by which we can be of most help to you and none of the decentralization indicates any lack of interest at the national level. Let us know if you find that something is going on that keeps you from getting a good job done. There is a difference between delegation and abandonment. This is delegation, but by no means an abandonment. If you find things that are not working correctly, our office and the national office is always available to review this.

Another issue that I'm sure is going to be coming to you, and again related to our topic of this morning, has to do with the fact that we are now undertaking an intensive study of the interrelationships between Comprehensive Health Planning, Parts A & B particularly, and Regional Medical Programs and the National Center for Health Services, Research and Development. They have a tremendous number of overlapping authorities and responsibilities. We are beginning to come out with some hypothesis that will be under test over the next few months and which will be discussed finally with your advisory groups, your coordinator and obviously with the Councils involved. It would appear that perhaps that a simplistic description of the role of Comprehensive Health Planning might well be that it has an obligation to deliver in an equitable manner, health care through the planning process obviously, not directly, in some geopolitical area, to a particular group of people. It has a continuing service obligation to that group of people in relating and planning to the services they receive and that is primarily consumer and public oriented as it were even though it must work with the whole system.

RMP as a complementary role begins to look as an activity which perhaps has a slightly different cast. It presents opportunity to a given area for innovation and affecting planning. It addresses itself primarily in its efforts to those people who have a responsibility for giving the health care, the professionals, the institutions, and the relationships between them and that finally it has a heavy responsibility because of this for educational programs addressed to that particular group. A National Center for Health Services Research and Development then becomes our study and evaluating arm and cooperative area where the research is perhaps more on the theoretical side, but nevertheless directly concerned with quality of health care.

As I look at the future then of RMP and for the purposes of this particular assemblage as you attack yourtasks in the next hours, by definition I think we have to come up with clarification of the relationship, not only between RMP and CHP in the national center, but with those other parts of Health Services and Mental Health Administration which is the national arm of health planning in one sense. Second, it seems to me that we are going to have to look very carefully at the kinds of authorities that have been delegated in these several areas and make sure that we are not duplicating in what we delegate to you, the regions or the programs. There is an agency-wide group that is looking at this process at the national level and I would hope that that example might extend in orther areas as well as it has in California to the fine cooperative work that has been going on here between particularly, the "b" agencies and RMP. We are going to be looking to RMP as the

agency with the richest contact with professional and with academic communities as the real resource of individuals who will, by the contribution they make to the planning process, be the catalyst force, in change. I've said this to the National Council and I say it to this group that there are many reasons why there is need for this role to be assumed by the RMP as an organization. It should not be placed in any kind of an advantageous spot because I think equally important that someone should be engaged in intensive study on the consumer and on the public. Only then can you have a meaningful dialogue.

I've asked the national council to begin to think about all of the HSMHA consultation in that kind of light. They looked a little dubious when I invited them to do that but they will find out sooner or later we really meant that invitation. Now, let me say two other things that you need to keep closely in mind when you think about RMP. There isn't, in my opinion, going to be any sizeable increase in funds in the immediate future. We have just been going through the business of the '72 budget and all I have to say is that after seeing what happened to some of the other groups, I've almost decided that holding the line is a gain at the moment. The crunch between the uncontrollables, which are coming up to a ceiling and it really is a very sharp ceiling, across the top of available funds, says that if you stay even in that kind of a decreasing space you are really ahead of the game and I think that's sort of the way we look at it. I'm not a pessimist. If we understand the ground rules we ought then to be bright enough to decide how we order our priorities and keep moving even though there may be some disappointments in not being able to do all those things that we have started out and thought we might do.

RMP is the best model yet developed for the incorporation of community action at the professional level into a change instrument for society. Its success or failure is going to depend on your willingness to look at whether that glass is half empty or half full. And I would hope that a measure of increase and resources is not going to be the only measure you're going to apply to whether or not you have been successful. It is my personal opinion that we will go through a plateau period, and that this is somewhat a testing period to find out whether or not RMP has found its place in concert with community, with the professional group and can develop an understood national voice that speaks very clearly to a wide number of people in high places who are still a little confused about what RMP is. I think your planning efforts need to focus in fairly rapidly on what RMP is and rather than focus on the business of all the global things it would have been nice to have done if you had had the money. I think it'll be much more profitable to look at the money you have, the need to keep that money fluid for innovative purposes then come up with the kind of solution that says very clearly to anyone and evidently to everyone we do have a role, it is important and we need your support. I volunteer to answer a few questions if there are some.

AUDIENCE QUESTION: I would like a clarification on the special bulletin for the $1.9 million dollars that is earmarked for the Model Cities program that correlates with RMP. I haven't got that squared away yet in our program and we need this type of information to know where we can go from there since RMP is the closest thing we can get to community groups, universities, and hospitals. This type of information needs to be explained now so we'll know what type of relationship we can work with RMP.

DR. WILSON: Are you speaking from the point of view of the Model Cities group?

ANSWER: Yes.

DR. WILSON: Let me respond to that. This is very much in discussion at the national level and I'm not going to give you as much of an answer as you would like because there's still substantial discussion going on. There are two issues at stake here, one appeals to Model Cities program has been given the task of working with a particular geographic area and with a geographic group. The RMP money comes from the national appropriation with certain restrictions and guidelines on it and certain inherent responsibilities for the quality of and the type of activity to go on this that resides in the National Council. Now the real question that's under discussion at the moment between Mr. Page, myself, Pat Hitt and others is "how do we keep the quality and consistency of use of that money which comes for a specific purpose at the national level at some kind of an understandable relationship with RMP and at the same time serve the needs of the Model Cities?" It would appear that the resolution is going to come out something like this: That as a matter of fact these perogatives will need to stay in the hands of the National RMP Council, the Model Cities will be encouraged to and helped in the process of turning in applications which will be competitive. The money will not as far as I can tell, be turned into a sum of money that will be turned over to Model Cities decision-making. That is a prediction on my part, not a settled fact. We, in fact, were just discussing this again within the last two days, but that's as close as I can get to it for you at the moment.

AUDIENCE QUESTION: I don't think that my question was directly answered. Will the money be turned over to Model Cities Programs? We're talking about some means of coordination where it can be

evaluated to the point that services are being given to indigenous communities, geographical or however you want to put it. How can Model Cities and RMP work together toward accomplishing this goal?

DR. WILSON: Apparently, it didn't come through, let me try one more time. I'm saying that the Model Cities group may function as applicants for this money. In that process one would assume they would not apply for money that wasn't in concert with what they are trying to do locally. If, in fact, that application meets the national guidelines and requirements that should put it into cooperative relationship to which your addressing yourself. The money that is earmarked for the Model Cities program is available only for use in those programs and the Model Cities people can apply for that as any other applicant which is the way it looks like it'll work out. We hope you won't apply for it in any way that is not consistent with your overall planning effort.

AUDIENCE QUESTION: What can Model Cities expect from RMP in the way of help in the health planning arena? At the present time, I represent San Francisco Model Cities. We have one person assigned, Virginia Greer, who is also assigned to Oakland Model Cities, and Richmond Model Cities. As you know, both are going into their action year. We are presently scheduled to move into our action year and yet we have not been able to get any help from RMP. It would seem to me an awful lot to expect one person to cover such an area. Are you planning to expand this role to have a meaningful effect into the Model Cities program?

DR. WILSON: Following the request that comes to us from the Office of Management and Budget, we are assigning people out into the regional offices as rapidly as we can consistent with the fact that we have had a restriction on the number of people, in fact a reduction in the number of people overall. The only way that we see that there can be some relief is through the RMP itself, which has some money that in concert with the other responsibilities they have could be made directly available by the RMP region that coincides with the Model Cities activities. Out of the regional office I do not see any relief within the next year as I look at the personnel ceiling, that would be of the substantial size to which you are alluding.

AUDIENCE COMMENT: It would seem to me, with the charge to RMP, there should be some kind of meaningful role to get involved with the Model Cities program. As I presently understand the role of RMP, this is the role that is supposed to be effective at the moment. Now what is your role with Model Cities?

DR. WILSON: Ours in Model Cities is quite like our role elsewhere and that is while we have authorizations, I would guess if we could handle all the authorizations we have we probably would be a 6 or 7 billion a year program. As a matter of fact, we have very real restrictions on any kinds of new money. Now the charge to work with the Model Cities is quite like our charge to work with Heart, Stroke and Cancer, with Kidney Diseases, which has been added, and others. We do not have any massive new initiative which we can invest in this from either the regional or the national level. This is going to have to be worked out with the RMP groups who have also other responsibilities and none of us are going to have enoguh to satisfy all of the needs which we think ought to be met. That's where I started and I think we have to face that pretty head-on and realistically. Yes, one more and I'm going to quit; I'm running into the next program. I'll be happy to talk to any of you individually after we finish here.

AUDIENCE QUESTION: What did you mean by saying the RMP had to avoid becoming involved in the costs of direct health care services?

DR. WILSON: I am alluding to the fact that there are $16 billion dollars being spent on direct health care services at the moment and that RMP has 100 million of it. Therefore it had to be very careful about addressing any of its dollars to those things which provided directly for the health care. It had to work with the system, with the planning and the innovative things and work with it in a way so it can withdraw that money and use it again for other innovations. That's all. Time limited projects are really what I'm talking about.

AUDIENCE QUESTION: So you didn't mean to imply that the provision of direct services was meaningless?

DR. WILSON: I meant to imply that it needs to work with the mechanics and the system for getting it done and it needs to do it in time limited projects. It does not get itself into the position where its money is continually absorbed for the same thing over a period of time. Continuing education being the one exception. If it doesn't work in time limited projects it will suffer the fate of the old chronic disease monies which finally became expected every year and were spent before they arrived and innovation sort of became tough to handle under those programs.

I'm sorry, this is helpful to me, but I think I had better let the chairman move on with his program.

DR. ANDREWS: Thank you, Vern. Dr. Wilson has agreed to react at the end of the program this morning. He has very graciously agreed to carry on his discussion in private with you and I hope you will take the opportunity to do this. We must hurry on with our program to stay on time this morning. Area II will present a discussion of their project concerning Multiphasic Screening to be given by Mrs. Jeanne Lebrun, the Associate Coordinator of Area III

VIRGIL GIANELLI, M.D.

Those of us in private practice of medicine have been well aware of the fact that in spite of our good intentions which include working far beyond the 40-hour week, society nevertheless seems to be disappointed in results produced as far as medical care is concerned. We, in San Joaquin County, in trying to analyze the problem, have for many years conducted dialogue with the consumer community. We started with the inception of the Foundation for Medical Care principle in 1954. The following year the Medical Society involved itslef in the health care problems of the migrant poor, which to us seemed to be the most disadvantaged medical grpou in the central valley area. Our philosophical thought is best expressed as far as I am concerned by Harvely Wheeler of the Center for the Study of Democratic Institutions, when he stated that a mark of a professional is he who does what ought to be done rather than what can be done. This then distinguishes a physician as a man of ethics.

We in San Joaquin have long been aware that medical care of migrants reached only those who considered themselves ill with no attempt to unveil occult disease. Little attempt was made to provide preventive care except in the field of sanitation and immunizations for children. Out of this arose the thought that perhaps Multiphasic Screening could serve as a vehicle to accomplish better health care of the rural poor who live in the sprawled ghettos of Stockton so that logically we could not distinguish between rural and urban poor. Accordingly, a Pilot Study of Multiphasic Screening was condcuted by the Foundation for Medical Care through an RMP grant from Stanford, Area III.

This Planning Study screened two poverty areas of Stockton both in the urban area, although migrants living in the area were screened right along with the urban poor. A total of 151 people were screened. Of the total number screened, 20.5% were found to have occult diseases, i.e., the screening produced findings that revealed new disease to the examining physician. An additional benefit was that 34.7% of the total screened were considered to be healthy. It was the recommendation of the Board of the Foundation for Medical Care that the major grant "A Program for Multiphasic Screening of the Urban Poor and Migratory Agricultural Workers in San Joaquin County" be approved. This Board also recommended that "services" be rendered. In this context, it was the intent of the Foundation to assure follow-up medical care to the individuals treated. The major program for Multi-phasic Screening was indeed approved by D.R.M.P. and in fact was given priority over many other projects. The program is now in operation.

The purposes of the Multiphasic Screening Project are:

1. To identify the health needs of disadvantaged groups in San Joaquin County, and to determine the extent and type of conditions requiring medical care.
2. To demonstrate that mobile multiphasic screening can be the energizing link between health needs and health services in a poverty community.

Some of the objectives of the project are:

1. To use mobile Multiphasic Screening for early detection in identification of pre-clinic abnormalities of cancer, heart disease, stroke and other major diseases.
2. To identify individuals requiring medical attention and refer them to the organized medical community for follow-up, diagnosis and care.
3. To use Multiphasic Screening as a portal to medical care and to actively engage the urban poor in a neighborhood health program, and the agricultural poor in a similar program centered in migrant camps.

To date over 1100 people have been screened. We have established a follow-up health center where screenees with positive findings may go for follow-up care. It is presently staffed by a full-time nurse coordinator whose duties will include the insuring of follow-up of all screenees with positive findings. This follow-up is to trace the screenee through the medical community and all the various avenues of health care. The follow-up health center was combined with the established Pear Sifford Foundation in South Stockton and the combined operation now carries the name "Pearl Sifford Health Center". Many years ago some of us developed the concept of a mobile medical volunteer task force that would deliver health care to those most in need of it. The Pearl Sifford Foundation, named after the relative of the principle donor, provides funds for medical supplies and has been in a Southeast Stockton ghetto for a period of four years prior to the Multiphasic Screening Project. The San Joaquin Foundation for Medical Care provides physician staffing and administrative support to guarantee adequate follow-up care.

We have strong feelings regarding community involvement. A Consumer Health Council has been incorporated and it is our desire that it become fully as strong as the Medical Society so that

equals can deal with equals. The organization of such a Council produces a major problem in that it has become apparent that of the 48 minority groups organized in the City of Stockton, a community of 100,000, there is very little inter-group communication. The organization of this Council has been and is one objective of the Director of Health Facilities, the Foundation's sub-contractor responsbile for screening. It must be emphasized that it is extremely difficult to develop an organization truly representative of a poverty constituency. The need of a common denominator was obvious. As an example of our problem, as far as the chicanos are concerned, there was a time when the church represented an area of agreement. But this no longer holds true. We would propose that interest in good health is a concept that is acceptable to all groups and as such can act as a unifying catalyst. It is interesting to note that the Consumer Health Council presented the Medical Society with three requests in the Health Check-up. These were:

1. Sickle cell trait determination
2. Blood typing
3. Pregnancy Test

After considerable interaction between the physicians and the Consumer Council it was agreed that only the Sickle Cell determination was pertinent to the objective of the program. This type of Consumer Health activity and interest we consider to be a valuable contribution to this screening. The necessary laboratory procedure, Sickle Cell, has been incorporated as part of the screening.

If the physicians are to be professional, then it logically follows that they must be involved in the problems of the city. We have come a long way from the Aristotelian concept that the aim of the city is to make men happy and safe. Health as an apolitical issue gives medicine a strategic opportunity to be deeply involved in the reconstruction of our cities. Although the new Pear Sifford Health Center was opened just October 12, 1970, we now are furnishing nurse coverage for eight hours a day, physician coverage for three hours an evening, a Drug Abuse Program for young people, including a training of street people to conduct rap sessions and to furnish crisis intervention by a 24-hour telephone service. Operational by next month will be a program of follow-up social work and medical service for the Order of the Good Shepherd. This Order counsels girls recently convicted of a felony as well as those who have completed their time at the San Francisco facility and have been returned to the area but who without proper counseling frequently return to their old habits. Also operational are legal services to the poor, the service of a nutritionist on a part-time basis; partly operational are the activities of the Welfare Rights Organization and in the planning a Center for the Elderly and also a program through the County Agricultural Department to provide development of family gardens under the concept that food production by the poor can partially return the concept of dignity to the disadvantaged.

As can be seen from the above, a simple procedure such as Multiphasic Screening expanded to include services has led to the establishment of a center that is able to fulfill the needs of a community and has given the Medical Society the opportunity for physicians to be leaders in the reconstruction of social order.

AREA II RMP - CHP "B" RELATIONSHIPS

CHARLES WHITE, PH.D.

In its wisdom, the 89th Congress created the Regional Medical Programs to make available the best possible patient care for Heart Disease, Cancer, Stroke, and Related Diseases. As a companion piece, the Partnership for Health Act authorized agencies to conduct programs of Comprehensive Health Planning for sub-state areas. The majority of these proved to be voluntary associations of interested organizations and individuals. Regional Medical Programs were directed to encourage and assist the establishment of creative evolutionary partnerships through cooperative arrangements among medical schools, research institutions, and hospitals. At no point in either piece of legislation was there mention of the other program, nor were there any instructions directing one program to relate to the other. For the first few months the programs did not relate to each other, in fact. A noticeable shift in emphasis began to be felt following the election of the Nixon administration and a series of formal and informal relationships have developed. From a prospective which is only slightly historical, I will consider the posture of the two agencies at the National, State, and Local arenas.

Prior to the enactment of 89-749 Community Health Planning in the United States had been largely non-prescriptive in nature, limited to restricted segments of health problems or special population groups. Vested in non-governmental health planning groups, individual elements of this system were dealt with selectively. Hospital Planning Councils, for example, were involved with facilities planning related to federal funding; Health and Welfare Councils indulged in some health planning and ad hoc citizen groups carried out one-shot health planning studies. Historically, the voluntary planning agencies carried out their functions without any formal regulatory authority or facilities and without control of government funds. The only notable exception was the franchising law of New York State which vested area hospital review and planning councils with a strong legal review function over facilities. Since 1966, a number of these pre-existing voluntary agencies have been recognized or have applied for recognition as the Comprehensive Health Planning Agency for their area; in other areas, new or autonomous voluntary planning groups have been established and recognized; in still other areas, governmental units have been recognized as the Comprehensive Health Planning Agency.[1] In general, the majority of the funded area-wide health planning agencies are non-governmental though the interests of the government are represented as required by law. Theoretically, the determination of the most suitable agency for Comprehensive Health Planning has been based on general agreement within the community that a particular organization is appropriate to conduct the activity. There are a number of reasons why the voluntary or non-authoritarian model was used for the organization of Comprehensive Health Planning Agencies rather than a governmental model. Historical precedent is one important reason. Congress, in its report accompanying the legislation noted the successful area-wide facilities experience of the Hill-Burton Program which was largely a voluntary approach and hope that area-wide Comprehensive Health Planning would extend and expand this success. In most areas, however, a more compelling logic lay behind the creation of voluntary rather than governmental health planning agencies. The health "system" is composed of sectors fragmented in terms of vested interest, ideological concepts, expertise, and functions. This complex structure is believed to make it impossible for planning technicians to plan unilaterally for health, and the governmental authoritary approach was rejected. A voluntary, non-authoritarian model was believed to be more appropriate in relating the multiple sectors since it emphasized participation in partnerships; it would promote expansion and major alterations in systems; it would achieve resource reallocation; and it would stimulate entrepreneurial response to health needs.

In section 314-B of PL89-749, the function of the "b" Agencies was described as "developing plans for coordination of existing and planned health services, including the facilities and persons required for provision of such services." This mandate lacks a clear concept of the operational steps which Comprehensive Health Planning Agencies should take. Many organizers, participants, and communities assumed that these new agencies would continue to operate through cooperation and advice without any particular coercive powers or regulatory functions. Indeed, most operational area-wide planning agencies have acted in advisory capacities. They seek to play major roles in planning through the collection of data, developing a broad-based constituency, assembling a competent and capable staff, through the assessment of needs and the bringing together of groups to discuss problems. This process has been hampered by unclear agency goals, conflict and lack of cooperation among the consumers and providers as well as conflict and lack of cooperation within each of these groups and the ever present political expediencies.

The original legislation which created both programs expired on June 30, 1970. It was therefore necessary for the present Congress to pass new bills if the programs were to be continued. One of the important preliminary steps in the legislative process is testimony before congressional committees. During much of 1969 and all of 1970, this process of testimony has continued. From it has arisen several broad streams of thought which I wish to summarize.

Granted that there are exceptions and what I am about to say is open to quibbling, these generalities are nevertheless true in the main:

1. The position of the Nixon administration has consistently been that the two agencies should merge under a common National Advisory Council, which would have reduced authority.
2. Comprehensive Health Planning has developed a public or consumer constituency.
3. Regional Medical Programs has developed a constituency among health service providers.
4. Comprehensive Health Planning is regarded as a planning-oriented agency.
5. Regional Medical Programs is regarded as an action-oriented agency
6. Decentralized decision-making should reside in the P.H.S. Regional offices.

During this period of testimony two very different philosophical positions emerged which could be described briefly as an Administrative position and a Senate position. The administration wished in general to merge the two programs under a common budgetary authority with Comprehensive Health Planning as the more dominant of the two. The senatorial position maintained that the two programs should continue relatively unchanged. A general drive was on during these months to consolidate many of the programs within HEW and the Public Health Service; Regional Medical Programs and Comprehensive Health Planning were not being singled for vengeance, punishment, or special attention. They simply were caught in the web of a larger game being played which was a larger degree of administrative control in Washington, plus a greater degree of decentralized agency control within the States and areas.

Finally, the period of debate was finished, and in the main the senate position has prevailed. Very few of the provisions the administration wished to include were finally incorporated in the measure signed into law only earlier this month. The categorical emphases of Regional Medical Programs were maintained with the addition of kidney diseases. Whereas, the original legislation was focused on making available the latest advances in the diagnosis and treatment of Heart, Cancer, Stroke, the new legislation focuses on making available the latest advances in the prevention, diagnosis and treatment and rehabilitation of persons suffering from these diseases. In addition to the functions included in the earlier legislation, the reasonable linkages promoted and fostered under Regional Medical Programs are to "strengthen and improve primary care and the relationship between specialized and primary care." The RMP's original mandate to "improve generally the health manpower facilities available to the nation" has been further specified to "improve generally the quality and enhance the capacity of manpower and facilities." For the first time then there seems to be a mention of quantity as well as quality. RMP's are to work to improve health services for persons living in areas where such services are limited. These ends are still, however, to be accomplished without interference with patterns or financing of professional practice or institution operations. This is a continued contribution to the lobbying power of the professional organizations which supported Regional Medical Programs and their accomplishments without surrendering these prerogatives. Regional Advisory Groups now will be required to include representatives of the State level Comprehensive Health Planning agencies and ex-officio representation from the Veterans Administration. It is suggested that sub-regional organizations such as the California Areas should include area-wide "b" Agency representations from their Advisory Councils. The reverse of the representation mandate is true for Comprehensive Health Planning.

The authority for grants and contracts has been substantially expanded from multiprogram services for conducting demonstration projects of control methods; the collection and study of epidemiological data; the conduct of cooperative clinical field trials; the development of special training programs; and special project grants for developing new means of developing health services with the diseases covered. On the financial side the administration requested $79,500,000 for RMP and the authority recommended by the Congress was almost $98 million.

The Comprehensive Health Planning Bill has not changed to any great extent. The specifications for membership in the State Health Advisory Council have been amended to include Federal as well as State and local agencies, such as the Veterans Administration and the Regional Medical Programs. State Health Planning agencies are directed to provide Comprehensive State Planning for health services, including Home Health Care. Further, the State's planning process is required to include environmental considerations as they relate to public health. Several interesting changes have been made in the area-wide health planning portions, although none of them are drastic. Area-wide agencies are required to consider Home Health Care services in their planning process. Increased funding was authorized for the next three years, although congressional appropriation and bureau of budget expenditures have never equaled authorizations. To summarize this laborious recital: various programs that would have been combined in a single title remain separately authorized. Multi-funding for programs in expanded data studies have been passed into law.

The lines of responsibility among the three programs have been blurred without clarification on relationships to each other. However, the department has sufficient authority to consolidate

programs in the absence of such legislation. The best illustration I have been able to devise is that of gazing down a set of railroad tracks to the horizon. The tracks appear to come closer together without ever definitely merging before they cross the horizon.

On July 1, 1970 there were 55 Regional Medical Programs, only one of which has not achieved operational status. At the same time, all 50 States, the District of Columbia, and 5 Territories had State Comprehensive Health Planning Agencies. One hundred-thirteen Area-wide, or "b" Planning Agencies, had received grants by that date. Thirty-five of those have achieved operational status. Still undefined are the relationships between the two programs. In California, however, a new ingredient to the mix has been added. Assembly Bill 1340 provided the power for area-wide "b" Agencies to become the kind of regulatory bodies they were not intended to be in their original conception. We are thus presented with the anomaly of a Federally created planning agency which is supported equally by Federal and local funds being directed by State law to perform a regulatory duty.

So now in considering the two programs from the State level, we must consider that the voluntary area-wide health planning agencies have been invested with decision-making authority on all applications to construct, expand, or alter health facilities for the purpose of increasing bed capacity or changing license or category. Is it desirable and feasible to combine planning and authoritary or regulatory functions in a single agency? Is it legitimate to vest regulatory responsibilities in a non-public agency? Will voluntary planning remain a valuable concept in an increasingly regulatory environment?

Five responsibilities have been commonly assumed by area-wide "b" Agencies and their committee structure reflects these concerns. They are: environmental health, health facilities, health manpower, personal health services, mental health and mental retardation. It is apparent that the regulatory function will begin to consume increasing amounts of time, energy and resources of the "b" agencies, possibly as high as 80 percent. If the health facility function becomes 80 percent, does that mean the other four committee functions must compete to divide the remaining 20 percent in time, money and staff resources?

Area II is a geographic entity affecting 20 counties in Northern California and three counties in Western Nevada, composed of 47,000 square miles of territory, with a population of 1,510,000 people. The area is largely mountainous, primarily rural in character with several clusters of population and several identifiable medical communities. Sacramento is the largest urban center, including in its sphere the University of California School of Medicine at Davis. The city of Reno is the urban hub of Western Nevada, including Washoe Medical Center and the new School of Medicine at the University of Nevada. Other medical trade areas focus around Travis Air Force Base in Upper Solano County; the Woodland area, Yuba City - Marysville; Chico and Redding. There are 73 hospitals in Area II with a total of 4,000 beds, this number is approximately 14 percent of the state total. Area II has 12 percent of those hospitals under 50 beds, 15 percent of those from 50 to 100 beds, and 21 percent of those from 100 to 149 beds. There are 1,963 physicians, 7,700 nurses, and several thousand allied health workers. In the past, referrals of certain health conditions were made to San Francisco or Palo Alto. As the School of Medicine at Davis and the medical facilities of the Sacramento Medical Center continue to expand in size and sophistication, a new service will be rendered to physicians and citizens in Northern California and Western Nevada through the opportunity for consultation and referral to the new center. In the publication, "Utilization of Treatment Facilities for Heart Disease, Cancer and Stroke in California Hospitals" prepared for CCRMP in June, 1969, overwhelming numbers of patients residing in Area II are hospitalized within their county of residence. Clearly they do not leave Area II in large numbers for other hospitalization and the most numerous transfer is to Sacramento, the nearest urban area.

Planning studies and educational programs in Area II have been hospital-based and involved extended learning activities transported to the hospital locations. In an attempt to serve each hospital within each county within each district of the area, large staff commitments of time and travel are necessary for field visits which are undertaken on a regular basis. These boundaries of Area II are approximately continuous with two Comprehensive Health Planning area-wide "b" Agencies. The Superior California Comprehensive Health Planning Association located in Chico involves the Northern Sacramento Valley to the Oregon border. Included are Siskiyou, Teham Trinity, Shasta, Lassen and Modoc Counties which comprise RMP Sub-Area District I, and Butte, Glenn, Colusa, Plumas, Yuba and Sutter Counties which comprise Sub-Area District II. The Golden Empre Comprehensive Health Council, located in Sacramento, includes El Dorado, Nevada, Placer, and Sierra Counties and are in RMP Sub-Area District III; Sacramento and Yolo Counties in RMP Sub-Area District IV. Therfore, of the 20 counties in Northeastern California which comprise Area II, 18 are included in the area served by Golden Empire and Superior California. Only Amador County, which is not a member of any "b" Agency Council, and the eastern tip of Solano, which belongs to the Bay Area CHP, are not covered.

Through the last several months, numerous planning meetings have been held among various persons within the three organizations as they have attempted to develop understanding and agreements. The discussions have centered around the merits of expanding the staff capabilities of both the RMP and CHP programs. It has always been clear that both programs can do a more effective job by expanding staff capabilities in two ways: by adding personnel to serve specific programs in planning areas; and by welding a close working relationship between the personnel of the programs - a relationship which avoids overlapping and takes the greatest advantage of the divisions of labor. Although the three agencies involved in Northern California have supported the building of cooperative relationships and deploying limited manpower resources as effectively as possible, it is still evident that the staffs are not quantitatively adequate to handle the jobs in view of the regulatory function which must be undertaken by the "b" Agencies. The statement will be particularly true in planning for personal health services and health manpower. In view of the background of the legislation at the national scene, we feel that the illustration of the railroad tracks directing towards the horizon is increasingly appropriate. The programs are obviously going to be pushed closer to each other by pressures from the national administraion. Political reality weighs heavily upon our thinking. For that reason Area II suggested that CCRMP should apply for an increase to support the core staff personnel budgets of each of the areas to prevent disastrous delays in the planning of programming for personnel health services and health manpower. If such funding is supplied to the RMP Area offices, it will not necessitate the raising of local matching funds -- a task which continually saps the strength of CHP agencies. Interagency staff personnel are perfectly capable of staffing committees without forcing changes in the legal requirements of advisory council representation. The quality of interagency working relationships has been such that the organizational location of new personnel is immaterial. I am impatient with those pettifogging arguments about the location of the officing and responsibilities of reporting, etc. If you are trying to build an empire this will be an uncomfortable arrangement, but if you are sensitive and responsive to the goals and missions of both programs, then the system is workable. If we are unable to solve such administrative problems such as personnel supervision, we deserve to fail in any case. Such increase in staff assistance and support is needed for the RMP District Councils I and II, which will incorporate representatives of the Comp Planning County Councils. Staff assistance will support the area-wide Personal Health Services Committee and the nine active County Personal Health Services Committee, the area-wide Health Manpower Committee, and the nine County Manpower Committees. Further development of manpower concerns involves a merged committee from Superior California Association, the Golden Empire Council, the Division of Allied Health Sciences of the School of Medicine UCD, the State and Community Colleges, and Area II. Program and multi-area planning has already been initiated through this mechanism. Area II does not have a separate manpower committee because of the existence of the other groups. Staff assistance is needed to help support the area-wide Personal Health Services Committee of the Golden Empire Council, the five active County Personal Health Services Committee, the area-wide Health Manpower Committee, and the five active Manpower Committees. Golden Empire Council is concerned with the problem of delivering health care to a metropolitan center as well as to rural areas. Sacramento contains all the health problems typically identified with delivery of care in cities since it serves the hub of the great central valley as well as the State Capitol. The Superior California Association has a primary concern for the problems of the delivery of health care in rural areas. As a planning agency in an entirely rural setting, it must be responsible for developing ideas, exploring alternatives and testing solutions. Established patterns of staff and committees of the three agencies will need to be supplemented by these new staff resources as well as special groups and new combinations of providers and consumers grappling with the twin problems of evaluating quality and quantity of health care.

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[1] Health Planning Issue Paper #3 "Areawide Health Planning Agencies: Can They Remain Voluntary?" New York: Community Health, Inc., May, 1970.

AREA IV NORTHEAST VALLEY PROJECT

LOUIS S. GARCIA - BARTON L. FISCHER, M.D.

I. BACKGROUND

The Northeast San Fernando Valley Project commenced operation in January, 1969. It was funded under the auspices of UCLA, Area IV, of the California Regional Medical Programs.

A. Target Area

The area chosen contains approximately 250,000 residents in 6 communities that exist in the Northeast corner of the San Fernando Valley which is located approximately 25 miles from the Los Angeles Civic Center. These communities include, Sylmar, San Fernando, Pacoima, Sun Valley, Sunland, and Tujunga.

The people vary greatly in ethnic concentration, years of education, annual incomes per family and in sophistication about health. Because of the high concentration of Mexican-American and Blacks in the "inner cities" of Pacoima and San Fernando (approximately 50%) the large number of welfare recipients and medically indigent persons, plus the lack of availability of health resources to a significant percentage of the population, the area has been termed a Health Ghetto.

B. The Objective

The objectives of the Project were to identify the health needs of the consumer, identify the health resources, identify facilities and amount of their utilization, to develop a viable medical, professional, and consumer Community Advisory Board, to promote health education and Health Career programs and to scientifically document and record the data collected.

C. The Approach

1. Preliminary Data

Data was collected by conducting approximately 30 Koffee Klatches with residents in the six communities representing the various ethnic groups. These groups were also selected to reflect different levels of economic and educational attainment. The questions asked at these Koffee Klatches resulted in clusters of health problem areas that the consumers were most interest in seeing resolved.

2. Questionnaire Design

The Soft Data collected at the Koffee Klatches was utilized to develop a Community Household Survey which was further pretested and finalized into what is considered to be the largest community household survey ever conducted in the County of Los Angeles. A professional consultant and bio-statistician were contracted to include the scientific design of the survey.

3. Sample Size

The sample size was selected at random utilizing the 44 census tracts that compose these 6 communities. It was designed to survey 3% of the residents in the inner cities of Pacoima and San Fernando and 2% of the other 4 communities. The reason for utilizing the above formula was due to the predominately Anglo population of the other communities.

This design provided 1460 homes to be surveyed of which 1139 were completed. When the business address and empty lots were deducted, the refusal rate was less than 8%.

4. Surveyers

Approximately 27 indigenous consumers from the 6 communities were hired and trained to conduct the survey. They represented the three major ethnic groups and were assigned to their specific communities. Because of the large number of Spanish speaking residents in the inner city, a team of bilingual interviewers were specially trained to handle all households requiring that skill. This approach proved to be very successful.

II. RESULTS OF SURVEY

The results of this Community household survey clearly indicates the need for a health educational system for improvement in the delivery of health services and for the development of a comprehensive health care system.

It dramatically points out the problems faced by the residents in three specific communities. (1.) In San Fernando, the problems are compounded by cultural and language barriers. (2.) In Pacoima, the problems are exacerbated by the large numbers of welfare recipients, high unemployment, and high concentration of ethnic low-income minorities. (3.) In Sunland, the problem is lack of facilities and services in the immediate area and isolation from any major hospital.

The results of our data has been further substantiated by other surveys which have been conducted. Pacoima has been designated one of the 8 needy communities in Los Angeles County. The best and latest survey was conducted by the American Public Health Association Community Health Action Planning Services for the County of Los Angeles* known as the "Merrill Report."

III. PROJECTED IMPLEMENTATION PLANS

The proposed Health Care System envisioned by the N.E.V. Project is composed of 6 components. These components will be implemented in stages and will require funding from a variety of public and private resources which are being negotiated at the present time. The components consist of:

A. The Census Tract Captain is the first component of the system. Research experience in many neighborhoods revealed that radio and television in general, the efforts of the Heart Association and the Cancer Society, and other public education endeavors do not reach very many people. In fact, only about 3% develop a reasonable level of the education in health matters that is available to the public today. This deficit is compounded in bilingual area. The position of Census Tract Captain, an intelligent, concerned and trusted individual of the neighborhood, who will conduct face to face programs on health education and health careers is proposed as at least a partial solution to this problem in the Northeast Valley. This individual will also act as the liaison person or health "ombudsman" for his community, thus expediting the communication of the sick of the neighborhood with physicians and hospitals.

B. Two Census Tract Health Stations, the second component, are envisioned as oriented toward preventive care. Each will be manned by allied health personnel such as public health nurses, registered nurses, licensed vocational nurses, census tract captains, indigenous health workers and, perhaps, "physicians' assistants." The Health Station will be capable of providing simple emergency care, immunizations, multiphasic health testing, computerized health histories, and health education. It will also be a training base for the San Fernando Valley Health Consortium (see below). The necessary professional back-up must be arranged with the private medical community,with a core medical group, or with the emergency rooms of a hospital near the station, or with a combination of these resources.

C. HMO is the third and probably the most important item for both physicians and patients. We have contracted with experts in the field of insurance. A Health Maintenance Organization (HMO) is planned which will utilize prepaid health insurance for patients without insurance, and will contract with MediCal and Medicare for comprehensive health coverage of their patients if and when it becomes legal to do so. This plan is designed to reimburse physicians and hospitals for their part in the provision of efficient comprehensive health care.

D. The Multipurpose Health and Welfare Center, the fourth component, has been studied for five years. If this components is to be realized, the Project organization believes it should be situated in the "inner city" -- San Fernando or Pacoima, it should contain the headquarters for all agencies that contribute to the total welfare of a family or individual (including social, legal, employment, housing, health, and other community services) and it should be bilingual.

* Merrill, Malcolm H., M.D., M.P.H., Future Directions for Health Services, American Public Health Association Community Health Action Planning Services, County of Los Angeles, 1970.

E. There are six hospitals in the Northeast Valley; they are the fifth component of this system as currently envisioned. It is hoped that the public hospital, Los Angeles County Olive View (and perhaps San Fernando Veterans Hospital), can become oriented toward acute care rather than limited to chronic diseases. It can then share in the medical care of lower middle-income families with limited resources, and perhaps can be encouraged to provide long term rehabilitation services. The four private and nonprofit hospitals may be incorporated into the prepaid health plan if they wish to do so.

F. The San Fernando Valley Health Consortium, the sixth component and final, encompasses the overall allied health education plan being developed by San Fernando Valley State College and the San Fernando Valley Regional Medical Programs. The appropriate delivery of health services is predicated upon the availability of adequate numbers of health care personnel to do the required job. The Northeast Valley Project has pioneered this program because of this fact and because it is believed that allied health careers offer upward social and financial mobility to minority groups. Also, the greatest lack of health services is in the disadvantaged areas in which these groups reside.

AREA V EAST LOS ANGELES CARES AND CONCERNS

Frank Aguilera , M.P.A.

Area V became involved in a stimulating and exciting project between February 1969 and February 1970. The purpose of the project was to collect information on the health care patterns and needs of East Los Angeles---a Mexican American community. The exciting element was that community health needs were to be identified from the point of view of the recipient of health services. Furthermore, the survey was to be conducted by persons from the community. As part of the methodology, the Welfare Planning Council of the Los Angeles Region, a non-profit planning agency supported by United Way, was given a contract to conduct the statistical research and data analysis required. Technical support and administrative coordination was provided by the staffs of Area V and Welfare Planning Council. Policy for program development was established by a locally generated steering committee. Representation expressing the point of view but not speaking for the diverse components which make up East Los Angeles was obtained on the steering committee from the providers of medical services, health-related agencies, community based organizations, youth organizations, consumers at large, and religious organizations. The end product of the project was the publication of "East Los Angeles Health - A Community Report."

The report represents one year of conserted effort during which concerned individuals with diverse backgrounds collaborated to develop an action oriented project whose impact would extend beyond its publication. The report was seen as the beginning and not the conclusion of RMP, professional, and community involvement working together to improve the health status of East Los Angeles.

Very briefly and without becoming involved in the politics of implementation, I would like to describe the major activities of the project, the main recommendations made by the community, the reasons why Area V approached the situation in the way it did, and the major accomplishments of the project.

Following preliminary organizational efforts to include community and professional input in the planning and implementation of the project, the first step was to determine the health needs of East Los Angeles, primarily as seen by the person using the health services. In order to obtain this viewpoint, a questionnaire was developed with the assistance of the steering committee which would be acceptable and relevant to the residents of East L.A. It was felt that traditional survey approaches would be ineffective. For this reason two bilingual East Los Angeles residents familiar with the community were recruited and trained in open ended interview techniques. Interviewees included over 150 community leaders and persons involved in the delivery of health services in East Los Angeles. They were selected because of their involvement in community affairs and because it was felt that they would reflect the viewpoint of large numbers of residents in East Los Angeles . Interviews of patients and clients were also conducted at various medical and health related facilities in East Los Angeles. The results of the survey and the health statistics compiled by the research staff of Welfare Planning Council and RMP staff members were incorporated into a preliminary report.

The preliminary report formed the basis for an open Community Health Workshop held on October 25, 1969, at East Los Angeles College. Over 400 residents and providers of health care services attended. The primary objective of the workshop was to validate the points of view collected during the interviews.

Based on the results of the Community Health Workshop, the preliminary reports were revised and sent to key policy makers in the health field with an invitation to attend a Community Health Conference. They were requested to react to the preliminary report which contained health needs and recommended solutions offered by the East Los Angeles community. The primary objective of the second Health Conference held November 22 in Los Angeles County/USC Medical Center, was to stimulate action toward implementing solutions to meet the identified health needs.

The recommendations which continually appear in the thirteen categorical sections of the report include the following:

1) More community control and participation in the planning of actual health facilities in the East Los Angeles area.
2) The establishment of local 24-hour multipurpose clinics which would provide diagnostic services, initial medical care and referrals.
3) The development of a bilingual information service or center to inform East Los Angeles residents of available health services.
4) The recruitment of more bilingual Mexican American people in health and paramedical positions of health delivery services.
5) The provision of low cost medical care.

The major recommendations and the preceding activities certainly sound somewhat removed from heart disease, cancer, stroke, and related diseases. How did Area V become involved in such a project? What was the climate like and what were some of the Area V concerns in late 1968 that led to such a project?

In a general way, the staff of Area V was aware that East Los Angeles had specific health needs characteristic of an economically deprived areain a central city. East Los Angeles covers an area of approximately 45 square miles and has a population close to 400,000. Approximately 70% of the residents of East Los Angeles bear Spanish surnames. The problems associated with poverty are often accentuated by a language barrier and a cultural background which often is inconsonant with the prevailing health system planned and operated by members of middle or upper class Anglo America. In 1965, almost one-quarter of all families in East Los Angeles had incomes below the "poverty level" index developed by the Social Security Administration. The median income was $5,100 compared to $7,100 for the County of Los Angeles as a whole. Unemployment in East Los Angeles was 7.7% compared to less than 5% for Los Angeles County. One-quarter of all families did not own a car. Thirty-five percent of all housing in East Los Angeles was either deteriorating or dilapidated. The median education of the East Los Angeles resident was 8.4 years of school compared to 12.2 years for the County. The dropout rates in local high schools were as high as 57%. Based on this information, East Los Angeles became a high priority target for Area V.

Operating on the generally accepted approach to community involvement according to RMP 1968, the staff of Area V made repeated attempts to involve the medical professionals in the East Los Angeles area. These efforts met only limited success. The concepts of continuing education, physician involvement and the RMP categorical approach to improved patient care were inappropriate in the barrio. It became necessary, therefore, to re-read the guidelines and redirect emphasis to the development of cooperative working relationships, not only among providers, but also among health related agency personnel and community based groups. It became necessary to begin to consider ways to assess the specific health needs of East Los Angeles to determine how RMP might best approach the situation.

In the process of obtaining documentation on the health needs of East Los Angeles, however, it became obvious that no substantive data existed on the health needs of the barrio. No complete documentation could be obtained from which a profile on community health needs could be extrapolated. Moreover, health as a concern for the East Los Angeles community, received low priority. Any effort to survey only the medical needs, or specifically the catastrophic diseases, would be doomed to failure. The strategy adopted was for RMP, through the Assistant Coordinator-Community Programs, to become involved in issues of concern to the community and eventually motivate it toward the problems of health. As some of the more basic concerns such as employment, housing, clothing, etc., were resolved in the community's hierarchy of needs, attention could then focus on health-related problems and eventually on the catastrophic diseases. Based on this analysis and the situation in East Los Angeles, Area V applied for and received $20,000 from CCRMP to contract with Welfare Planning Council to conduct a survey to document the health needs of East Los Angeles. Because of previous inability to motivate participation by East Los Angeles physicians, a decision was made to conduct the survey from the point of view of the consumer.

East Los Angeles is a community which like other economically deprived areas has been studied and surveyed with no visible positive follow-up. Community support for the project was therefore begrudgingly given, but only after assuring all concerned that the survey would be more than a report to collect dust on some agency bookshelf. The report would be by and for all concerned. The entire project was oriented away from the concept of planning for planning, and emphasis was placed on planning for action.

The major accomplishments resulting from the project include the following:

1) Publication of "East Los Angeles Health - A Community Report." The report is documentation of the health needs of East Los Angeles as perceived by the community. It includes original statistical research on the health needs of the East Los Angeles study area. The report has been used by both community-based organizations and official health agencies in developing proposals to implement specific solutions. In the process of conducting the project, community organizations and official agencies have worked together to focus on the health needs of the community.

2) The recommendations contained in the report were reviewed by the Los Angeles County Board of Supervisors. Subsequently, the Board of Supervisors directed all departments concerned, namely, the Department of Hospitals, County Health Department, and the Department of Mental Health, to implement the recommendations requiring only administrative decisions and to return to the Board of Supervisors the recommendations requiring policy changes. As a result, both the Department of Mental Health and the County Health Department now offer evening clinics. An alcoholic

rehabilitation clinic is operating two evenings a week in East Los Angeles. A drug abuse clinic has been established at the Northeast Health Center in the East Los Angeles area.

3) The Board of Supervisors has announced plans to construct a $4 1/2 million neighborhood health center in East Los Angeles. Plans are currently being developed with the cooperation of the Citizens Advisory Council to the East Los Angeles Health District.

4) Area V has partially funded a project to develop an integrated health care system for senior citizens in East Los Angeles. The idea originated with the senior citizens of East Los Angeles and was submitted to Area V, Regional Medical Programs through the Los Angeles County Health Department. The project will involve voluntary health agencies, physicians in private practice and local medical facilities in East Los Angeles.

5) The position of Special Assistant on the Health Needs of Spanish-Surnamed Americans has been developed by Dr. Egeberg in the Department of Health, Education and Welfare in Washington, D.C. This appointment was a direct result of a commitment made by Dr. Egeberg during the East Los Angeles Health Conference. The screening and recruitment process was delegated to a committee composed of representatives from community health organizations and the district health officers from the two health districts in East Los Angeles. Area V staff provided administrative coordination and technical support to the committee. Similar positions have been created by the Department of Hospitals and the County Health Department in Los Angeles County.

6) "East Los Angeles Health - A Community Report" has been circulated among Federal agencies by Congressmen Brown and Roybal resulting in an increased awareness by federally funded programs about the health needs and problems in East Los Angeles. In short, the project has produced visible community oriented changes in local as well as national institutions.

Currently, we are concerned at Area V with evaluating the future role of RMP in East Los Angeles. Budget constraints and lack of staff prohibit direct RMP follow-up of project recommendations. Efforts are being expended, therefore, to enable RMP to continue its role as a catalyst. The next logical step is to increase the involvement of medical professionals in East Los Angeles and develop a bridge between professionals and the recipients of medical care involved in health activities. We also hope to develop closer working relationships with other Federal programs in East Los Angeles. Although the staff of Comprehensive Health Planning in Los Angeles County has been kept informed of RMP activities in East Los Angeles, no cooperative working relationships have as yet been developed specifically for the East Los Angeles area. A closer working relationship is being developed with Model Cities in the Northeast/East Los Angeles area.

As a member of the staff at Area V, I am particularly concerned by what a participant in the East Los Angeles Health Conference described as "the cancer in the East Los Angeles community." I am concerned because if not properly treated, the patient will die and the cancer will spread becoming even more virulent and with increasing potency will engulf our entire society.

In closing, I would like to quote from the Report of the National Advisory Commission on Health Facilities, published in December, 1968:

> Health needs originate in people and in the community. Health facilities, inescapably, must relate to the people in the communities they serve.
>
> There should be community responsibility with both consumer and provider participating in decisions. The consumer must be involved in planning, policy setting, and assessment of adequacy of the services provided.

These are statements made almost two years ago. At that time, they were recommendations. Today, in East Los Angeles, they are closer to becoming reality.

AREA VII PHYSICIAN CONTINUING EDUCATION THROUGH A RESIDENT PHYSICIAN SABBATICAL EXCHANGE

MARION MYKYTEW, M.D.

I would like to give a brief description of Area VII and of our proposal in Physician Continuing Education which is presently under review in Washington, D.C. The Sabbatical Exchange Program is one portion of this physician education proposal. A list of activities of Area VII, including pilot and study proposals, has been duplicated and is available for distribution.

Area VII consists of the two southermost counties in California, San Diego (the 2nd most populous county in the State) and Imperial, a sparsely populated predominantly desert area. The counties are about equal in size (4200 square miles) with a total population of 1.5 million, but 95 per cent of the population reside in San Diego County while 5 per cent, about 80,000, are in Imperial County. This area, adjacent to Mexico is bilingual and multicultural including a substantial representation of American Indians. The area has 33 acute hospitals, 20 of which have less than 100 beds. There are 4 community hospitals in Imperial County, all under 100 beds and located 15 minutes apart and about 150 miles from the University Hospital in San Diego.

There is a severe shortage of physicians in Imperial County as well as of nurses, dentists and other allied health personnel. Forty-six physicians practice in Imperial and of these, about 20 are in general practice, 3 are internists and 1 is a pediatrician. The trend in Imperial County over the past ten years has been a gradual decline in the number of practicing physicians. There is one group practice of four physicians, several partnerships, but most are in solo practice. Fifteen physicians have practiced in Imperial County over 20 years. Many of the younger physicians who do come, stay a few years then usually leave for residency training.

Early in 1969, members of our Area VII Continuing Education Committee held a series of meetings with medical staff members from community hospitals in the two counties. Hospital staffs expressed their interest in "problem oriented" continuing education programs which could be integrated with their practice at the community hospitals. The medical staffs of hospitals most distant from the University Hospital were particularly interested in resident and sabbatical programs which might be developed with the new UCSD School of Medicine. A proposal was developed for Physician Continuing Education in Community Hospitals which included the following components:

1. A major educational technique of the proposal is medical auditing. Medical Audit Committees at community hospitals will identify needs for continuing education and will also evaluate the effectiveness of the subsequent educational experience. The program will provide consultants to assist community hospitals in establishing and utilizing the medical audit.
2. Cooperative arrangements will be developed among groups of hospitals to share one Director of Medical Education.
3. Consolidation of hospital staff meetings will be developed in order to decrease the large number of meetings attended by many physicians who may be members of 5 - 10 hospital staffs.
4. A Guest Resident Program will be established, modeled after the Bingham Associates Program at Tufts-New England Medical Center which pioneered in regional medical programs 30 years ago. A resident or fellow will spend one week per month at community hospitals where he will transmit information and demonstrate how certain clinical problems are handled at the UCSD Medical Center.

A pilot project was begun in September of this year when a Fellow in Pulmonary Disease from University Hospital was sent to Imperial County. The program includes didactic lectures (for physicians and allied health personnel), walking rounds, demonstrations and consultation clinics. At the end of the week, Grand Rounds are presented. Allied health personnel and faculty from the Department of Medicine also participatedin these one-week programs. Programs are planned with the Chiefs of Staff, nursing directors and hospitals administrators following recommendations made by the hospital staffs. The Director of this Project is the Professor and Chairman of the Department of Medicine at UCSD.

5. A Sabbatical Exchange Program is proposed which will allow the community physician to leave his practice and come to the UCSD Medical Center for a 2-6 week period for intensive work in an area of his interest. Arrangements will be available for a resident from the UCSD Medical Center to serve as locum tenens for the physician during his sabbatical period. The training program is planned jointly by the physician and his faculty supervisor.

A pilot sabbatical program was initiated this past summer when a letter from the Dean's office was sent to physicians in Imperial County inviting them to participate in a Sabbatical Program at the UCSD Medical Center. Funds were not available to enable locum tenens arrangements or to cover travel or per diem costs for the participating physicians. There were no charges for participation in the program but it is recognized that the loss of income during this time is significant. Nine physicians (seven specialists and two general practitioners) have so far participated or are scheduled to participate in this program. Some tried to use

their vacation time for the program but found this detrimental to themselves and their families. To date the response of participants have been most enthusiastic. Most physicians have spent 1-2 weeks at the University Hospital. One physician spent 4 weeks. The two general practitioners have arranged one day per week programs on a continuing basis. We believe that locum tenens arrangements will facilitate the participation by more community physicians.

Coordination for the program will be achieved by a joint RMP-CHP Health Manpower Committee. In Area VII, CHP has the same boundaries as RMP. Early this spring the RMP Continuing Education Committee merged with the CHP Health Manpower Committee in order to eliminate duplication of efforts. Merger has also occurred of the CHP and RMP Committees in Imperial County. The merged RMP-CHP Health Manpower Committee has three Task Forces, one of which is on Physician Continuing Education . Members of this Task Force constitute the same members as the Continuing Education Committee of the San Diego County Medical Society, again eliminating duplication of effort.

Administrative responsibility for the program will be in the Office of Health Manpower of the UCSD School of Medicine. The Associate Dean for this office is the Coordinator of Area VII, Dr. Michael Shimkin.

The Guest Resident and Sabbatical Programs were developed in particular response to the needs of the more rural communities in our two counties. The pressures of patient care lack of many specialists for consultation and the geographic isolation of physicians in Imperial County are obvious.

Faculty of the UCSD School of Medicine, pressed by the demands of a developing school have recognized a responsibility to serve as a resource for the continuing education of the medical profession in our community.

The program is mutually advantageous to the participants:

1. The practicing physician gains access to a source of new knowledge. He has first hand observation of tested techniques. In addition to the specific clinical training, an ancillary benefit is in acquainting the community physician with the new personnel and developing capabilities of the Medical Center. He learns at first hand what is available to him and his patient and he meets on a personal basis with many of the specialists to whom he may have referred patients.
2. For the faculty and students of the Medical School, continued contacts with the realities of daily practice are necessary if our teaching is to be relevant. As the community physician returns periodically for the sabbatical experience, he will become more comfortable in the academic environment and assume more of a teaching role during rounds and conferences,etc., basing his comments and observations on those of the community practitioner as contrasted with the specialist or subspecialist in a teaching hospital.

The aim of the program is to establish close and continuing contacts between community physicians and the Medical School, enable the physician to resume his professional education and keep the practitioner under the influence of the medical school throughout his active career.

DR. ANDREWS: While Doctor Wilson is coming to the podium, I want to take this opportunity to thank the presentors, both last night and today, for the insights they have given us into the activities in the various Areas in California. The presentations have been good and I think we've all profited by virtue of them.

SUMMARY REMARKS

DR. WILSON: There is very little that one can add to this kind of a program that I think will provide you with additional input. Mrs. Wycoff was regaling me this morning with something that I don't think she expected to turn up here. Apparently, the YWCA group whose initials appeared on the podium dates back to the early days when this auditorium was built. It was called, as I understand, the"Ground Gripper Group." That was apparently in contrast to the flapper group at that time. As I listen to the several presentations made by this so-called Grass Roots organization if you'll allow me to push this analogy a bit further, it seemed to me that the Grass Roots organization indeed had a pretty firm grip on the ground and that promises very well, I think, for sound growth.

Let me react, if I may, to several threads that seemed to run through what was said this morning without making any attempt in this brief seven or eight minutes, to critique each of the presentations. Over and over again it appeared very clearly that cooperation is truly a personal matter. It's not mandated, it is not forced, and as a matter of fact, is only a result of mutual confidence and trust between individuals who are really accomplishing the task. It's not sent in from a distance -- it's a part of what individuals are doing on behalf, usually, of someone else rather than themselves. The future of RMP as an organization so far as I can tell, is going to be dependent on your ability to build on what we have heard today. I've been to so many conferences and in so many discussion groups that I always approach this with a great sense of hope but also with a sense of caution because I do know that even though you're in relaxed clothing, in a way we're presenting our Sunday appearance. I hope that what we have heard here this morning is the core of your intent -- that it is, in fact, in evidence of what you do when you return to the several places where you are serving because if, in fact, this is California Regional Medical Programs, the country will have but no alternative but to support this kind of activity and our plateau in funding I think will be only temporary.

Now there is one thing that I want to repeat, because as I listen to the several programs, in some of them run the threads of the possibility that individuals become so impressed with the importance of what they're doing that they'll put more and more funds into the central activity and a smaller percentage of funds into the periphery and into those things which will run their course and be renewed. May I ask again the question that, if you want to be a leverage group; if indeed you want to deal with self-renewal in RMP and in the system in the same sense that John Gardner, I think, intended in his book on the general issue of self-renewal, you must be very careful that you don't become so impressed with the importance of what you're doing personally in your own group with these kinds of monies that it becomes caught up in your activities and perhaps begins to exclude the start of the very basic and very important things we've heard from several of the projects.

Let me give two other brief notes and stop this part. I don't believe I've ever heard a more eloquent exhortation than two of the papers that so demonstrated the forcefulness of the community involvement. I was particularly attracted to the last one with community involvement of the youth. You will find Secretary Richardson has talked rather forcefully to all the agency heads on Tuesday of this week and said, "The next two members of every Advisory Group in HEW will be individuals who are to be classified as youth." And if any agency head wishes to deviate from this, he'll have to explain to me why he was deviating." That's an interesting sort of a statement. The other comment is that I would hope that as we go through the process of sending responsibility and authority to the Regional offices that you will intensively and positively explore the way in which they can use their new responsibilities and their new authorities to assist you. One must always look forward in this kind of process, and this is a process of change.

The HEW Regional offices are themselves undergoing change. If they aren't responsive yet, they will be responsive to the problems that may come from these centralizations. I do hope you will use this heavily and as you work on these problems you will call upon them for advice and consutlation and something that may be a little more readily available, their personal attention to the issues with which you are struggling. Now I promised I'd deal with any kind of question you might wish to pose. I savedhalf time for you. I took half and you have half, and I'd be glad to respond to leftovers or challenges which I didn't respond to the first time that you'd like to bring up now.

AUDIENCE QUESTION: I wonder if anyone in HSMHA, the RMP, or CHP is looking at the various bills in Congress for restructuring the health care delivery system?

DR. WILSON: The restructuring of the health care delivery system, interestingly enough, has been tossed in the lap of HSMHA. Now you asked if we were looking at it and yes we're looking at it with concern, a little bit of horror and considerable apprehension about the time constraints under which we're functioning. As we look at the health options which were recently requested on a three-week deadline period we had all of the agencies throughout the federal government together. This included the Department of Labor, OEO, and the Veterans Administration. The whole group met to talk about these options and in turn to talk about their implications as related to both the pending legislation and potential new legislation. We, I think are not sure and I'm a pretty new arrival in Washington to be at least personally assured that we comprehend all of the implications of these interrelationships. The direct answer to your question is yes, we're trying, we're doing the best we can and we will in a relatively early period of time be turning to various kinds of community groups who are struggling with problems and asking them to participate in these discussions as well.

AUDIENCE QUESTION: What role do you see for RMP in the development of health maintenance organizations if the amendments to the Social Security Act pass?

DR. WILSON: I wish you hadn't asked that. I'm going to tell you a little bit more about penguins than you asked to know. The Health Maintenance Organization activity is probably one of the most over-described and least understood of activities I've ever witnessed. The 17-550 amendment addresses itself to a very specific issue and that is "Is there a way you can take the payments which come from Medicaid and Medicare and address them into a new kind of organization that would provide cost reduction in the Medicaid-Medicare Program?" I hope we haven't overlooked the fact that there are 6 million people in this country who are already getting their health care from what could be very generall termed Health Maintenance Organizations and have done this without any help from HEW, Thank You.

Now within that kind of a set of limits, there was a group of very interesting young gentlemen, none of them from health fields, who worked for several months on what they considered to be health maintenance organizations and did it on what I rather crudely called the filling station theory: if you build more of them to compete, you'll get gas at a lower price. Now I would submit that that's not the way the health care system works. One of the leadership gentlemen went to help in a campaign in one of the states and HSMHA inherited the health maintenance organization activities about three weeks ago. There's sort of a feud on this now long-discussed but little-clarified issue. We have a task force working on it. I have a notebook with 200 pages of briefing which I read all the way from Washington to San Francisco last night. I'd have to that it's a pretty good encyclopedia of the issues, but I wish somebody would tell me exactly how to resolve it. There will be, I think, a resolution of at least the initial attack on the Health Maintenance Organization thing at our level fairly quickly now and proba restricted to just this Medicaid-Medicare packet at that moment. As soon as that's done, the issues that are descending upon us may well be evolved by January 1. And we have to get some general community involvement in that set of discussions. There are a great many professional organizations who have a right, a responsibility, to be as much part of this as they can before the regulations come out. We obviously are working intensely with Social Security and the others. A direct answer to your question is that I think that in this particular phase we probably will not have the kind of time it takes to get a meaningful interaction with RMP and the others in this initial cut at the regulations response to 17-550. That is simply the opener. It seems to me when we begin to deal, as we must, with the general impact on the health care system and health maintenance organizations in the generic sense, then RMP will be very much a part of this and that'll be on a slower time table.

AUDIENCE QUESTION: I have a feeling and I want to get your reaction to it. My feeling is that all of a sudden this will become law and all of a sudden there will be a frenzied need for production in regard to it and then all of a sudden somebody will start looking around for money to put it across and then all of a sudden RMP and its funds might loom as a possible source and then priorities change.

DR. WILSON: That's sort of an "over my dead body." We went through that discussion some time back and everybody gracefully backed off on that one but there will be 8 million dollars placed in the treasury of the National Center for Health Services Research and Development to be expended by my office directly for the pursuit of HMO and that's the expenditure. For the next two years, as I think I was implying less directly earlier, we can keep the momentum going in some of the strong programs like California. I don't think there's a danger of anyone wanting to obliterate this kind of a program or detract from it for other purposes.

AUDIENCE QUESTION: About continuing education function in RMP. I wonder if you would elaborate on that, hopefully reassuringly.

DR. WILSON: Well, my allusion to continuing education was in the context of my sort of admonition or urging or whatever you want to call that gentle pushing I was doing to be sure that you don't get your funds all tied up in service. But I said that there was one area where you would have a continuing obligation and that was in continuing education because that's another kind of change agent. It is quite clear that at the national level there are even substantial people that think that should be the prime and almost only activity of RMP. This I think would be disappointing and selling far short. It is very evident that it will always be a substantial part of the activities of RMP insofar as the current legislation and I read to you an abstract from the Current Register that will be going in that deals with continuing education as a major part of the activities. I hope we don't get caught, of course, in the trap of traditionalism when we're dealing with continuing education. I'll take one more question and I think we'd better quit.

AUDIENCE QUESTION: You spoke of decentralization in RMP - I wonder if this applies to HEW in general? I'm referring specifically to last year's policy of direct funding to the migrant health project without going through the state agencies.

DR. WILSON: Decentralization applies to HEW generally. I'm most knowledgeable about HSMHA activities. Roughly one-third of our deployable funds - the ones that aren't caught up in some kind of a grip like the public health service hospital - are now being expended with the primary authority and responsibility in the regional office. We have tended in those instances to keep research grants and training at the national level and to look at health service as something that would be deployed by the regional offices. The migrant health worker program is coming out of the Regional not the national office. Any migrant funding is coming from the Regional. We're still in the process, and I'm pretty new at this business of finding out exactly how it is that you get the right communication between the Regional office and the "b" agency and the local professional group and if there's any one extra-curricular in the loose use of that word where I've spent a lot of time it's on California either by telephone or personal visit where some folks forget about some of the common amenities of courtesy in doing this sort of thing. You know these are inexcusable, in personal or official relationships. I hope we're getting to that issue somewhat. We will continue to be making the grant as such from the regional office for the migrant health worker projects and others. That does not mean, however, that this won't be subject to substantial discussion with the "b" Agency group and with the local professionals and those people who have who have a right to be involved because they finally wind up doing the work. Does that speak for your question? This is decentralization.

AUDIENCE COMMENT: I just wanted to mention one thing, that Dr. Wilson felt they had their Sunday clothes on and he wouldn't have to chance to critique their papers. We did that for Dr. Buggs on Monday just so he wouldn't have his Sunday clothes on. He thought we wouldn't have time to do it, but we took care of that.

DR. WILSON: I was sure someone would. I one time heard a speaker use something which I will rob and repeat now, that "You've been an excellent audience. If you have another chance to be an audience, don't miss it."

GENERAL SESSION

Friday, October 30, 1970

8:30 a.m.

DR. ANDREWS: We will move now into the reports of the workshops which were held yesterday. This should, I think, be the highlight of this program, because it represents the conclusions of your collective deliberations.

WORKSHOP 1

Area Region Relationships

William A. Markey

Workshop #1 progressed through three groups. These groups brought forth a wide range of interpretations of the question "What about Area-Region relationships?"

The range of interpretations was from a formal chart of organization in a military type delegation of duty from national to Regional to Area, through the essential abolishment of California as a Region, and the making of each Area a Region in and of itself. This latter interpretation brought out that there are similar kinds of difficulties in the Area-Region relationship and the District-Area relationship in those Areas which are organized into formally structured districts.

By and large, all groups seemed to be accepting of mutually supportive roles with strong local participation within the overall Regional framework. It was felt and agreed by most members of the groups that if the mission of the California Region were described frequently and sincerely with reference to the Areas, then a total structure which allows for Area input could predominate. For example, "The purpose of the California Region is, through its Areas, to provide improved regionalization of health care services throughout the state." The phrase "through Areas" should be used frequently in describing the activities and goals of the Region.

With respect to priority setting, there was fairly good consensus that Regional guidelines are needed as a framework within which the Areas should function. Areas then would set their priorities within this framework and in keeping with documented needs of the Area. This, it was felt, would provide the highest and best use of the existing resources, and should point the way toward discovery of needs which are not now being served.

It was generally agreed that the Region should not expect to impose specific priority goals within an Area not ready to accept or recognize these needs as being higher than a locally recognized priority.

Informal priority setting by the Area Advisory Group and core staffs was discussed. It was pointed out that use of staff time for small studies and similar means to achieve regionalization, involvement, or other catalytic activities will undoubtedly continue without the laborious major project development and review processes. It was felt that this was an important element in the overall effectiveness of Area activities, and that this informal priority setting should probably receive formal recognition.

Discussion was held in one group relative to the political influence from Washington or from state officials on operation of a given Area. The example given in this group was the appointment of a person as program director who had once been a political opponent of a congressman. The group was unable to resolve this particular problem; but it did, in discussion, point out ways in which members of Congress might be informed about RMP activities in their respective districts.

The review process was discussed by all three groups. Most questions dealt with the forthcoming Annual Review process, the developmental component, and the Region level funding decisions which are implied. An important suggestion was forthcoming from one group, with concurrence by another group: The technical review report should be made available to CCRMP as well as to the Area Advisory Group, with a staff summary of discrepancies and changes made by the Area to meet deficiencies, and that an abstract of the proposal rather than a personal appearance by the proposer should be presented to CCRMP. It was felt that the proposer, who might by the time the proposal is complete have only faint resemblance to his initial thought included in the project, would have presented activities to the various technical committees, the technical review, and the Area Advisory Group. He would still look forward to a presentation at the RMPS site visit. It was felt that if a written summary, in terms which would be easily understood by all members of CCRMP, including community representatives, were to be presented without an individual "pitch" for each proposal, that CCRMP would be able to make a more sound judgment relative to the importance and relative position the proposed project would have in the total scheme of California RMP

planning.

It was felt an important ingredient in the review process would be that CCRMP should view itself as a defender of any project which it approves for funding.

Other discussion covered:

RMP's possible role in the implementation of health manpower organizations, national health insurance, and similar programs.

RMP's role in expanding basic medical health education capacity of the country.

CCRMP should provide clear criteria for project and core acceptability. This would help Areas in the selection of material or projects presented.

The importance of some fund flexibility at the Area level was emphasized. This would be for pursuit of locally important information for studies or public relations activities in a format which is appropriate and to scale for each Area to use.

Finally, it was emphasized that each Area Advisory Group and CCRMP should have the internal strength to be able to say "no" when indicated. This was with respect to the forthcoming Annual Review process, and the need for a more clearly defined program for California in RMP.

WORKSHOP 2

Category Disease Planning Versus Comprehensive Medical Care Planning

Sam Sherman, M.D.

Groups B, C, and D met and discussed the question of: "Categorical Disease Medical Care Planning versus Comprehensive Medical Care Planning."

The first issue for this discussion revolved around the original intent of the legislation implementing Regional Medical Programs. It was agreed that the categorical approach in planning was necessary in the early days of the program because of:

1. The high incidence of mortality and morbidity of heart disease, cancer, stroke and the related diseases in this nation.
2. The pressures of the professional organizations and voluntary agencies whose traditional interests were in these disease categories.
3. The ease of planning and operational programs concerned with educational activities designed to upgrade care for a few diseases rather than for total medical and health problems.
4. Improvement of professional skills in limited disease categories was more readily achieved in a limited program as compared to a more comprehensive one.
5. Initial guidelinesand directives specified that this approach was to be followed using cooperative arrangements with physicians, institutions and communities.

Initially there was polarization, but finally there were common areas of agreement. All groups agreed that much has been accomplished by the categorical approach and that it should be retained as a base but it needed broadening and updating. Many gaps in medical care have been identified, particularly since consumer input has been added to the professional input. More visibility to Regional Medical Programs is needed in order to receive increased consumer and professional support and acceptance. Almost all discussants recommended increased flexibility by expanding the categorical approach and including comprehensive medical care planning. Increased emphasis on preventive services, social services, continuity of care and all types of rehabilitative services is needed in the future development of programs. Elimination of fragmentation and undue duplication should result from this new direction.

Primary care was defined by all three groups as "any modality which permits a person to have entry or re-entry into the medical care system." This may be achieved by a multiplicity of methods and through any member of the recognized health team.

It was noted that Regional Medical Programs has been instrumental in promoting the acceptance of the health team for management of diseases, utilizing a multidisciplinary concept for total care.

All groups agreed that Regional Medical Programs should assume a role in providing equity of access to health care, increasing quantity of health care, and higher quality of health care using the educational methods which have been so successful in the categorical programs. With this issue resolved, the three groups recommended that Regional Medical Programs should relate to primary care particularly where there are gaps in the delivery of health care, be they in rural or urban areas. This role can be either as a catalyst or a coordinator and should be carried out when requested by Model Cities Programs or Neighborhood Health Centers or any responsible community or group of

consumers.

Furthermore, in cooperation with "b" agencies of Comprehensive Health Planning, many needed health manpower and personal health services problems could be remedied in the future. These cooperative efforts would possibly lead to innovative health delivery systems acceptable to both the professionals and the consumers. Overlapping and unnecessary duplication of the two programs would be materially reduced if not eliminated by this "collusion course".

In conclusion, it was agreed that in order for Regional Medical Programs to remain viable, category disease planning must be expanded and made more flexible. Health professionals and allied health personnel must be offered realistic incentives for creating new and exciting programs with both educational and health delivery components. The total health needs of consumers should receive primary consideration, and if new legislation or new guidelines or new relationships with other agencies will be required for this -- so be it!!

WORKSHOP 3

Health Manpower and Regional Medical Programs

William Monroe

President Nixon has recently announced a survey which disclosed that there was a shortage of 40,000 physicians in this country. He pledged the support of his office to overcoming this "medical gap." However, Dr. Wilson has told us that there has been no increase in the level of funding for health services for fiscal years 1971 and 1972, and that he anticipates very little increase for the following year. At the same time, three universities have indicated major financial problems in keeping their doors open for medical students. St. Louis University, Marquette University and George Washington University have indicated that they may close the doors of their medical schools next fall. In view of the lack of priority assignment to funds and the funding problems of the universities within the United States, what can Regional Medical Programs do to close this health manpower gap?

Insofar as continuing education is concerned, the Regional Medical Programs' efforts in the past have been largely organized around the categories of heart, cancer and stroke. Continuing education has dealt with training physicians and allied health workers to man Coronary Care Units, to provide stroke teams for stroke units and other categorical approaches. Some areas have offered short seminars but report inconsistent response, some courses being well attended and others are not.

The question of the physician-assistant is one that Regional Medical Programs must deal with. Physician-assistant training has been organized primarily on a categorical basis - training physician-assistants for pediatric work, expanding the role of the nurse and similar activities. Although a new law has been signed into effect in California, the rôle of the assistant physician has not been defined or licensing procedures developed. This is an area in which Regional Medical Programs can become actively involved and can alleviate the pressures on the physicians by defining the role of the physician-assistant and seeing that he is adequately trained to assume duties wherein lesser than physician skills are required. In addition, in order to effectively utilize the physician-assistant, the physicians themselves will have to be trained to work with their assistants.

It has been recommended that Regional Medical Programs utilize its influence to require attendance in Continuing Education courses in order that licenses may be retained. This is currently being considered as a requirement by the American College of Family Practitioners. A word of caution, however. The doctor is an hourly worker. When he takes off from work to attend class, his income stops. He is , therefore, required to consider training on a cost/benefit basis.

In considering allied health works it should be pointed out that the role of the nurse today is really quite different than that of 20 years ago. However, there is no well organized reorientation or training courses for older nurses. Regional Medical Programs has a role in bringing together representatives of nursing education and nursing associations to develop appropriate curriculum whereby nursing skills can be updated.

Brought out in the workshop on health manpower was the practice of physicians issuing standing orders, permitting nurses to treat patients in their absence. Considerable discussion took place as to the legality of this procedure. In the County of Los Angeles, nurses and firemen have been identified and trained for rendering emergency medical aid to coronary patients. In order that they may do so, however, a special law has been passed in the State. This law permits the cited practice only in counties with populations exceeding five million persons which automatically excludes all other counties, except Los Angeles.

Consideration should also be given to upgrading the skills of other health workers such as LVN's and Community Health Aides. Well-organized efforts such as those being carried forward in Area VII (UC-San Diego) should be emulated with CRMP. It was noted that in some areas medical technicians were trained in such numbers that they cannot all be placed in internship positions in their area. It should, therefore, be the responsibility of RMP to survey the total field to match skills against requirements. It will be a matter of coordination to assure a balance between the supply and demand for health care delivery services personnel.

The Health Consortium is a new concept which may be utilized to assure comprehensive health care. The difference between the health consortium and an inter-disciplinary medical team is that the whole consortium is a group which is trained to work together as a unit to view the patient as a patient rather than to look at him as a set of individual diseases.

WORKSHOP 4

Regional Medical Programs - Comprehensive Health Planning

Michael Shimkin, M.D.

I also sat through three sensitivity groups and they were supposed to react to three questions:

1. What should be the relationships between RMP and CHP?
2. What should be the relationships between RMP and Model Cities or other Federal programs?
3. How can the RMP develop multiple sources of funding?

All groups decided the answer to all three questions is "yes." I think we all realized that although we talk knowingly about sub-segments, that the health industry can be called a non-system. It is, however, far to the rear of another non-system in this country called health legislation. So we find ourselves talking in cliches. Obviously, everybody agrees that we should work together. Obviously, the goals, if not identical, are similar. Obviously, the way we proceed with it is determined by the acts or versions of the Acts under which we work at a particular time. I don't know that we have any alternatives. It is not in our wisdom, to decide, for example, that RMP related more closely to health manpower and primary health care and the role of providers than CHP, whose role is mostly planning and facilities and represents more strongly the consumers. This is the way it was written -- all we are doing is regurgitating and then deciding this was our decision. We really had very little to do with it. As a matter of fact, in most of our minds, there occurred the sad thought that despite the reorganization of RMP to the so-called newly defined goals the only really viable act we had before defined heart disease, cancer, stroke to which kidney disease has been added. The rest is really our interpretation.

What are these legislators trying to say to us? Is it possible that to them the old flags of heart, cancer and stroke have more appeal and heretofore perhaps have more funding in the future than these overall goals and cliche words such a comprehensive? I wonder whether this is what is in the legislative process we have seen before us.

All of the groups agreed that the RMP-CHP orientation alone is too narrow. Written into law are many other pieces of legislation which interpret Federal activities at the local level. Certainly in most areas you'll find that monies, if you want to be so crass as to talk in those terms, are much fuller in terms of programs under Model Cities and OEO and none of us have developed any meaningful relationships with these organizations. There is a lot of expression of mutual need on both sides, yet how that mutual need is to be fulfilled is not quite plain. Most of us were RMP people with a few from CHP and a few from other agencies -- we all agree that Model Cities need our help terribly much. I don't know that Model Cities is quite as firm in that contention. The point is that we in RMP cannot wait for Model Cities to come to us and ask for our help. We have to go and talk to them at the people to people level to define their problems and help them without offering the threat of taking over. So somewhere in this public relations scheme perhaps something can be worked out.

We also discussed whether there should be a more formal relationship between RMP and CHP at any level. We came to a Solomonic decision that perhaps we better leave that one alone too! Sometimes solutions to the problems are worse than the problems themselves. Since we are getting along not too badly in our present relationships, let's try that way rather than to call for some artificial mechanism that may or may not work. When I say we I'm not too darned sure whether it is me talking or any of the people in these groups, but this is sort of a free-wheeling summary.

Yesterday, Dr. Wilson told us about a decentralization of these programs and indicated that this should occur at the HEW regional level. Having had experience with this kind of decentralization in the past, some of us have concerns about that! Perhaps Dr. Smith will talk about it, but the recent course of events would indicate that the HEW regional offices do not have the capabilities or capacities, and so admit, to carry out any of these functions. So often what results is

another stop gap in the ladder and some of us would rather deal with Washington directly, if Washington is equipped to respond quickly to our needs. At any rate that's one of the problems we have to deal with for which I don't think there is any particular solution, at present.

So in conclusion, we sort of concluded, that we wouldn't conclude anything, and indicated that the two states we certainly are faced with and have to live with and can live with are: 1) keep our options fluid, and don't come to any cosmic decisions too quickly, and 2) maintain as good a sense of humor as this pain allows.

WORKSHOP 5

The Committee

Charles H. White, Ph.D.

The total group that came to this conference is approximately 60% RMP staff; 20% advisory committee members; 20% staff members of other agencies with planning functions. As one attempts to share skills, knowledge, and understandings in the performance of our staff roles, "The Committee" topic was chosen as one of the workshop subjects.

The groups varied considerably. In some groups the subject itself was under discussion for long periods, but in other groups it served only as a vehicle to get onto other more serious business. We were able to identify a number of reasons why committees exist: as a way of sharing responsibility, of encouraging participating, as a division of labor, of performing an indepth study, as a way of collecting expert knowledge, as a way of performing a task in the most effective manner, and in some cases as a political device. This discussion of the types, functions, and roles of committees led us to a thread of consensus that ran through the day that frequently, in our own organizations, we know these are some of the purposes of committees, but we also have some committees that don't seem to match any of these committees. One of the two of the very explicit conclusions that were able to be drawn is that it may be time to reorganize and re-examine our structure. Remember, the structure of your program may have been built upon a review and grant project application building scheme. That scheme may no longer be a reality. The development of grant proposals may have been able to run its course. We may be moving, instead, toward fewer standing committees, fewer long-term groups toward more issued-centered, time-limited, task-oriented committees which are called into existence to do a job and then are called out of existence again. We contrasted this with a group of a series of traditional groups that just go on and on sometimes long past the point when they have any reason for existence.

The other thread which we discussed thoroughly was: if we are no longer building grant proposals that call for a different theory of staff roles, the staff work then becomes committee-centered in a process of being the broker or catalyst among people or organizations. This removes some of the tangible ways of dealing with problems. As long as you can chase a grant proposal you have something tangible to work with. When that's gone, some of the security is removed for the staff. They must then try to formulate a substitute set of goals.

In one particular group, there was unanimous agreement that staff members themselves were extremely unclear about the purposes of their agencies. This seems to bear out the suggestion that we need to re-examine our own structure and programs. We ought to do some more considering about what is the role of the staff person, in view of the changes of directions of the program that were indicated yesterday.

WORKSHOP 6

Regional Medical Programs and Voluntary Health Agencies and Other Non-Federal Agencies

William C. Fowkes, Jr., M.D.

Three very informative and interesting workshop sessions were held covering the above subject. It was the consensus of opinion that the definition of a Voluntary Health Organization was any organization that responds to public need and does not as a routine get funding from the Federal Government. In addition to agencies such as the Heart Association, the American Cancer Society, Kidney Foundation, etc., we can include some hospitals and free clinics. It could be stated that a Voluntary Health Organization is a group of people organized to handle a particular problem, raise its own money for its own cause, and self-organized by citizens with specific goals.

Given the foregoing clearly defined definition, its was concluded that there is literally no limitation on the extent to which we might work with Voluntary Health Organizations. As the goals of these organizations continue to broaden, their importance to RMP will continue to grow and through cooperative arrangements we can address ourselves to specific health care problems.

There was considerable discussion as to how RMP should relate to such agencies on a regional and on an area basis. It was agreed that this very much depended on the individual needs in a particular area. The association would in all probability be task-oriented and the kind or scope of ties be appropriate to local situations. This is simply a way of accomplishing the ultimate goal for which both are aiming. It was a concensus that the relationship of these organizations with RMP could not be defined from a national,regional or state level, if task-oriented relationships should be handled on a local basis or neighborhood basis.

There was little question of any conflict in any of the areas between Voluntary Health Organizations and RMP other than the possibility of competition concerning visibility or recognition between the voluntary agency and RMP. There was some feeling that the Regional Medical Programs needed considerably more visibility and more recognition for its coordinating function in order to accomplish its mission. This is not the case with CHP. There was almost universal feeling that the voluntary health agencies and CHP were in direct conflict because of the necessity for CHP to solicit funds to raise its 50% share from the same constituencies as the voluntary health agencies.

The categorical nature of the voluntary health agencies was felt to be at some odds with present goals of the RMP but it was the general feeling that these organizations would adapt and that their resources could be mobilized in more comprehensive and broad programs appropriate to local need. There was general feeling that categorical programs will continue to be developed though in a somewhat more limited scope and that we must strive to continue our excellent relationship with the voluntary health agencies for mutual benefit.

There was a tendency in each of the three workshop sessions to move from the association of RMP and voluntary health agencies to the relationship of RMP to Model Cities and there was feeling that RMP staffs within personnel and time limitations should work intimately with the Model Cities programs and help them develop their health components.

WORKSHOP 7

Core Staff Structure and Function

Al Torribio

What constitutes a good core staff?
In what ways can personnel be shared between Areas?
What are the skills of planning? How can they be utilized? Who has them?
What is the relationship between core staff and Area Advisory Councils and/or District Committees?

A "good" staff requires a frame of reference. In RMP this reference is difficult. For example, a basic RMP concept is Regionalization but planning involvement requires grass roots contacts. For this reason there is a movement toward sub-regionalization, and sub-area or District development. The staff's relationships to constituents are affected by:

Changes and uncertainties in the law. Changes in program relationships, emphasis, review and approval mechanisms. Changes and delays in funding. (For example: How long should a project be carried as a part of core funding when an approved but unfunded project may never be funded because of changing program emphasis?)
The function of core staff may be affected by a change in RMP from the role of solicitor and/or screener or projects to health system transformer.

What constitutes a "good" staff? Good will vary with the size of staff, the area to be served, and the expectations of the community and university. With all the above changes, one of the primary skills expected of staff is the ability to function efficiently and effectively in the face of change. Money is a prime need for staff development. RMP programs with multiple staff members can exchange experiences and develop group support of endeavors. Isolated or small staff feel alone and overwhelmed at the magnitude of its tasks.

A good staff should develop community acceptance. This can be accomplished by persons from a variety of disciplines and ethnic backgrounds. Staff should trust and accept the sound decision making capabilities of volunteers. Listening skills, ability to draw other members of the university out into the community, and their acceptance of new ways to deliver health service are important attributes.

As a catalyst and idea broker, staff should avoid putting old wine in new bottles and know how to tap various funds. Staff should not become emersed in medical care to the detriment of their continuing education responsibilities.

Community volunteers are not concerned with professional jealousies and status problems

but rather with health care needs. They expect staff to know who should be involved. As a change agent, staff should encourage RMP organizational change when structure no longer fits the program goals or objectives. In moving from project to system approaches, communities should be prepared for the wind-up of projects and not left high and dry after project funding ceases. Shift in program emphasis may require new team members.

Few Areas have had experiences in exchanging or sharing staff. Some do draw on the knowledge and experience of others and have also provided considerable assistance to CHP staff.

In regard to staff-board relationships. The term "advisory" needs clarification. Should boards develop policy? Should they hire and fire? The workshop groups indicated wide variance in practice. One Area Board hires and fires all members of the staff, professional and non-professional. In another, the Coordinator hires and fires and may or may not tell the Advisory Board. In one Area, staff members assist committees only when invited to help. In others, the staff decides when to convene Committees to seek their help. There was some need expressed for staff title clarification. How do planning officers differ from assistant coordinators or grant management personnel or project coordinators?

All staffs should have periodic self appraisals of their role, functions and accomplishments. Goals and objectives should be reviewed. Volunteers should be involved in this process because in some instances, they change, and accept change, more readily than staff. Increased involvement of more consumers in RMP should be encouraged.

Finally, staff should develop faith in the future of RMP, hope in RMP goals and its relationship to other federally related programs. Above all, staff should maintain a charitable attitude toward national and regional administrators who have a most difficult job.

WORKSHOP 8

Regional Medical Programs and Medical Schools

John H. Stroessler, Ed.D.

In the early sixties public attention was focused on the three primary diseases of mankind: heart disease, cancer and stroke. President Kennedy appointed a blue ribbon committee headed by Dr. Michael Debakey to study possible ways to make inroads into conquering these deadly killers. The Debakey Committee recommended the establishment of specialized clinics throughout the country to bring together the foremost authorities in these fields. Following lengthy debate, Congress passed Public Law 89-239 and in October 1965, President Johnson signed the heart disease, cancer and stroke amendments establishing the Regional Medical Programs. This law provided that the Regional Medical Programs be established within the university environs rather than in new specialized medical centersbecause it was thought that the knowledge which was centered in the medical schools should be made available outside the cloistered halls to the practicing physicians throughout the country. To date fifty-five Regions have been funded for planning activities.

The California Region operates through the California Medical Education and Research Foundation headquartered in San Francisco. The Region is then divided into nine Areas, one at each of the nine medical schools in the State of California. This is a unique arrangement for the RMP's throughout the country but seems to have worked well because it permitted the California Region to get an early start and made available funding for the four newer medical schools in the State earlier than would otherwise have been possible.

There have been, of course, differences of opinion as to the relationships that medical schools have with Regional Medical Programs. It has been feared by some that the medical schools would resist community programs because they would tend to divert the focus of the professors from the realm of academe and dilute their efforts through widespread cooperative arrangements with many other agencies. Actually, through the RMP mechanism, mutually beneficial arrangements have been developed between the teaching physicians, the community physicians, and allied health personnel throughout the Region in a way which has never been done before. Some of the general questions growing out of this new relationship which we have discussed at this conference are:

What are the relationships between the RMP and the medical schools?
What are the advantages or disadvantages of these relationships?
How can these relationships be made more beneficial?

We also directed our attention to some of the "nitty-gritty" interface areas pertinent to carrying on the everyday work of the RMP's under the University aegis. These included:

1. Objectives
2. Administrative policies
3. Facilities and equipment
4. Personnel
5. Finance and accounting
6. Support services
7. Project proposals
8. Public relations

Opinions expressed during the discussion were spirited, sometimes heated, and frequently diametrically opposed to each other. The following represents a consensus--there is neither space nor time to report every point no matter how eloquently it was presented.

Most medical schools adapted smoothly to the new conditions and philosophies of the RMP program. However, those of traditional orientation felt resistance toward expanding the medical school's dual role of teaching and research to include concern for community-oriented medical services. This resistance was reinforced by the resentment felt by socially conservative faculty members to anything that smacked of government influence. It was also held by some that the community must come to the medical schools to partake of any of its benefits. Consequently, the early proposals submitted for RMP consideration were academically oriented, beneficial primarily to the medical schools and in many cases basic research in nature. RMP coolness to this approach was readily apparent, and these institutions began the grantmanship game anew under the ground rule that acceptable proposals were community-oriented. The pertinent questions now became: "Should RMP projects be designed to reach the few people who need the most help or the most people who need less?" or "Should RMP efforts be defined by community members who define what they want so that medical schools will meet their standards of patient care services?"

There is no doubt that these are concerns basic to RMP success with medical colleges. People in needy areas are still distrustful of the medical school's influence in RMP. They feel that the programs are not sufficiently realistic to their actual care needs. Many in underprivileged areas are troubled by the belief that the medical schools are interested only in using them as guinea pigs.

But the climate is changing. Medical schools are responding to the challenge of meeting community medical needs, especially when defined by joint cooperative means between community and medical school representatives. Medical schools feel the pressure of taxpayer demands for producing treatment-oriented physicians; they are responding to the pressures of medical students who clamor for instruction which is relevant to the needs of the community.

Spurred by this, the medical schools are reaching out to the community. They are conducting projects which bring their personnel and resources to the community. True, it is not as widespread and far-reaching an effort as many would like, but progress is being made. Medical schools are forming departments of community medicine to facilitate bridging the gap. They are beginning to consider the employment of non-physicians in those departments and personnel who may lack academic degrees, but who can measure up to new criteria of competence and make vital contributions rom a base of rich experience in community life.

Medical schools find this new role a beneficial one for establishing good public relations. And RMP has found that affiliation with the medical schools has lent stability and prestige. Some RMP groups prefer to be housed on campus to strengthen their identity with the medical school. They value and utilize the supporting services -- computers, publications, etc., and the access to consultation and professional expertise which the medical school can offer. Other RMP groups place more value on being located off campus in the community neighborhood. They do not want exposure to the possible risk of medical school domination. They do want closer identification as a community agency. (Some even get better parking accommodations this way!) Some RMP groups have solved the problem by having both kinds of locations. For the medical school which has accepted responsibility for community medical service, what better established vehicle for action than through RMP?

RMP groups which have made the greatest progress in developing fitting relations with medical schools are those which have taken active steps to surmount obstacles created by obscurities of national policy, unapproachable deans, and ivory-tower faculties. Cooperation and involvement are key words in this process. Cooperation versus demand; and involvement through service.

In conclusion, the relationship between RMP and the medical schools can be, and generally is, a good one. It expands the medical school's role into an extremely relevant social one of providing community medical service, it builds a bridge between medical school faculty and practicing physicians with resultant facilitation of continuing education, and provides a solid resource of technical expertise for RMP to draw upon for the effective realization of its objective: the provision of improved health care.

DR. BUGGS: I think this conference would be of a great help in settling area-region relationships and core staff structure and function by answering one question. That one question can be answered in two words, either singular or plural. I would like this from each of the panelists. With regard to the area coordinator, who does the hiring and firing in California? The governor, the Regents, the Board of Trustees in the private schools, the Board of Directors, the Chancellor of the respective campuses or the dean of the Medical School? I would like that question answered.

DR. ANDREWS: Are you speaking in relation to the Medical School only?

DR. BUGGS: Yes, to the medical school in regard to the appointment of the Regional Medical Program Coordinator.

DR. SHERMAN: In Area I, I am certain the hiring is through the Office of the Dean with the concurrence of the Chancellor and a committee that has been appointed at the University to oversee Regional Medical Programs.

DR. WHITE: In Area II, a search committee was formed by the Dean including faculty members and the area advisory council to interview candidates and make recommendations. From that point on, the answer is all of the people you named. The Dean must recommend to the Chancellor and to the Board of Regents. All these persons must approve the appointment of the coordinator who is a member of the faculty and goes through all the normal process of faculty appointment.

DR. FOWKES: The Dean in Area III.

MR. TORRIBIO: In Area IV, the Dean appointed the only coordinator we have had. I don't know what the process will be in the future, but I suspect it will be different, because there was one area council when the coordinator was selected.

MR. MARKEY: In Area V we have a similar pattern of little experience in this matter, but the one time that it happened, it was done through the dean's office and the dean's recommendation. I don't believe that it went on to a board from that point.

MR. MONROE: In Area VI I belive that the Board of Trustees of the University was involved in the choice of the coordinator.

DR. SHIMKIN: The usual complicated mechanism affected Area VII. Somebody nominates and it has to be approved through channels by faculty members then it goes, after filling out scales of papers to at least two faculty committees. One committee examines whether you are a good boy and have had a number of publications. Then it goes, really, to where the decision making is important -- a budget committee which questions whether or not it can afford you and whether you are a good investment for tenure. Then all of this gets gathered together and the Dean talks it up to the Chancellor. At one time decisions were delegated down to each campus, now the Regents must make that stamp of approval. After a month or a year you get the appointment settled. It is a very complicated process.

DR. STROESSLER: I'm not sure how this works in detail in Area VIII, but I would assume it would be as Dr. Shimkin indicated for the University of California system, originating at the Dean's Office and progressing on from there.

DR. ANDREWS: Dr. Buggs would you like to tell us what your plan is for Area IX?

DR. BUGGS: Only that I will see if I can decifer these remarks. I did not get the clear-cut answer in two words, but we will try to discover where the authority really lies. If it has to go to the Chancellor and from the Chancellor to the Board of Regents, then as I see it, we are excluding the democratic process in selecting because you have ruled out all community input.

DR. ANDREWS: As I heard people from Area IX yesterday, I don't think they are going to permit this process without being involved.

AUDIENCE COMMENT: I'm from Area IX, and I'm not going to deal with the Board of Regents but you are here from areas and it could happen to you, too, if you let a Congressman throw an appointment back in the faces of the people. We have a Dean, but we don't have a school yet. We're playing games, never to have anything for the poor. I'm not about to come here and let all you learned people make reports without going on board with me by saying you support what we

have tried to do in our area. Now we've kept guidelines so far as that goes; but the guidelines are all over because we didn't bring the Congressman in at that time. We have gone through due process which was wrong. We had community input, we've given our findings to the Dean, and the Dean has made his appointment. Now I understand Governor Reagan will have something to say about it on Monday morning. That's going too far. If he has something to say about Area IX, he's damn sure going to have something to say about all the rest of you eight areas. So you may as well throw that out of your minds and Paul may just as well get ready to go home and all the rest of you. When one Congressman can upset the whole RMP program, you haven't got anything anyway. All I want is support from you that you understand what we're trying to do and say to us that you're willing to work with us in some manner.

DR. ANDREWS: I don't think you understood the answers. In five of the schools the appointments do not go further than the Dean. The rest of them do send appointments to the Board of Regents. There is no policy.

AUDIENCE RESPONSE: I just wanted you to understand. You answered beautifully. We will set the policy.

DR. ANDREWS: I think the participants of this conference are to be congratulated on the input they have given to these workshop chairmen which generated the reports this morning. I think we've gained insight into the activities and the level of thinking in the California Regional Medical Programs. Are there any questions you wish to address to the panelists?

AUDIENCE QUESTION: Neil, I noticed a lack of any comment during these proceedings about an opportunity to explore one of the new manpower models we have been talking about for some time, that is the physician's assistant. We have legislation in California now that will enable us to develop and employ such persons. The Board of Medical Examiners will try to define these types of individuals and establish programs for them. It seems to me that RMP has a very vital input in the development of that role and the definition of the training and function of a physician's assistant. I wonder if anyone is thinking about this. I haven't heard any comments.

DR. ANDREWS: Does anyone on the panel have a comment?

MR. TORRIBIO: In Area IV we had a meeting with the head of the MEDHIC program for returning servicemen who are looking for jobs and Dr. Fitzhugh of the Watts-Willowbrook-Charles Drew MEDEX program which is patterned after the University of Washington. Also there were representatives of the California Medical Association which has a committee concerned about the role of paramedical people and some representatives of voluntary agencies, and health departments who are also experimenting with nurse assistants, family care practitioners, pediatric nurses. We have gathered quite a stack of literature and program knowledge of all of these and are gradually becoming very sophisticated about the various aspects relating to them. The question is a crucial one. How do you plan for health care in situations as described by an Area II field representative such as a three-county area with one dentist; or when the only hospital in the county has 22 beds with one 66-year-old physician who just had a coronary. It's a crucial question in many of the urban as well as rural areas. A new project has just been started at Berkeley to train women as family health practitioners. I think there are 15 public health nurses in that program. Is that correct?

AUDIENCE RESPONSE: I think you are giving the State Health Department credit which it does not deserve. The University of California School of Public Health has a grant for a development program for a family nurse practitioner. The first six students were admitted this fall.

MR. TORRIBIO: When these girls come out 18 months from now we hope they don't go to another state because these kinds of people are being looked for now and we had better plan to utilize California-trained people.

DR. FOWKES: In Area III we have been involved in a couple of programs. One is a physician-assistant program, which was submitted to RMP in a project called "Integrated Assistants" which did not pass at the division level and was returned. However, the people who developed the program originally are moving ahead and will probably accept their first students around January 1, 1971. A lot of work has been expended and the formal B.A. program will extend 18 months. It will accept a variety of applicants with health backgrounds, including medical corpsmen, nurses, or anyone with an interest in health fields who has appropriate background. In addition, a complementary program will attempt to duplicate in a civilian hospital the training of corpsmen to feed into the formalized physician's assistant program. Also, we have a neophyte pilot nurse practitioner program that began September 20, 1970. We have five nurses who are going through a four-month program centered at Stanford Hospital but which involved preceptorships in the community.

Mrs. Jeanne LeBrun has been the major organizing force behind this program.

AUDIENCE COMMENT: We discussed in our group yesterday the area of allied health professionals. This is really what we are talking about today. One person doing his or her thing to produce five or six people here or there. We're talking about meeting a demand which far exceeds this. We're talking about a school of allied health professionals which would bring together all of these types of people, upgrading professionals across the whole gambit to meet the health manpower shortage to free up the physician so he can really do his job. I'm not aware that in California we have a school of allied health professionals, but it is in the talking stage. We also discussed that RMP in its affiliations with all of the universities would be one of the greatest vehicles to plan the implementation of such a school to meet the shortage we are discussing today.

DR. BUGGS: I wish to clarify something. I don't want this audience to leave with the idea that the MEDEX program we have spoken about was developed by the University of California. The Charles Drew Postgraduate Medical School has an affiliation with both UCLA and USC. Through the School of Allied Health Profession there will be similar affiliations with state and community colleges,elementary and secondary schools. The MEDEX program proposal was written by Dr. Al Haynes, who is chairman of our Department of Community Medicine. Because we do not have at the present time a functioning hospital, the affiliation with the Medical School at USC provides the clinical and didactic training at the present time. The MEDEX program is a part of University of Washington MEDEX program developed by a black physician, Dr. Dick Smith. At the present time four of these programs were funded as one package. One of the training programs to be based at the Drew school. Dan Grindell, formerly training coordinator for the King Hospital, modified the MEDEX program and that project is known as the Physician's Assistant Program. We are pretty sure that is going to be funded through Model Cities. The training will be done at the University of Southern California.

AUDIENCE QUESTION: Gentlemen I would like to know if it is possible for this body since we are sandwiched between two major conventions, the APHA and the AAMC (Many people from the RMP will attend both of these) to give any recommendations to the AAMC in regard to manpower training? That's what it's all about. Where are we, RMP, in terms of making recommendations to the AAMC in terms of training? I know some papers are being presented by members of this body. This is our best opportunity to get started in the area of manpower. Can anyone say what is planned for presentation or recommendations in the name of RMP? What is our attitude toward that convention?

PAUL WARD: I suppose as a group we have a great many individual ideas about it, but we have no synthesized position that has come out of debate on the issue. Naturally, from my own point of view, I'd like to see things done logically, but as I've said many times I don't hold much hope that this will be the case. If we were to do it that way, I would like to see RMP have the courage, and belive me this would take a great deal of courage, to say that we should start licensure reform now before we get into various training courses with licensure and certification at the end, and before we categorize people. We don't need more levels of manpower, what we need in the health field is the ability to go from one level to another without confusion. If we had the collective courage to go before the legislature and ask for changes in licensure and make one broad license available to all personnel, with certain qualifications within that one single license, We'd be doing the best thing that can be done. I tried once as many of you will recall. Until that time, I had been fairly friendly with nurses, therapists and others, but collectively they were very angry with me when I suggested that procedure to the legislature. Nothing was done. I don't think anything else is worth doing at this point. Sure, we could train more people to serve in the health field, which will further complicate things. But if we really want to do something worthwhile, we take on that questioning of licensure and we create the ladder approach which we've discussed many times. We would need to fight many of our own groups which are involved with us here today -- those that have vested interest. It would be a bloody fight. I wonder if we have the courage or the ability to come to that conclusion.

MR. TORRIBIO: There are also some other allied schools which are developing and unfolding besides the one at Charles Drew. One is at California State College, Bakerfield, one is in the planning stage at Valley State College, San Fernando, one is at Fresno State College.

AUDIENCE COMMENT: In our last discussion group last night, we had a minority position concerning political activism. If RMP and CHP really have a vital future, it must be as political activists. We suffer from a lack of credibility and one of the ways we are going to get credibility as part of the process of bringing about change is moving legislatures, changing laws, and restructuring the system as we know it today. That requires political involvement.

AUDIENCE QUESTION: I have a couple of questions I want to ask. I'm from Model Cities in Oakland. I've really enjoyed this conference, working with the groups and playing football. After listening to the great White Father yesterday, speaking about the National policy, and the groups discussed problems that are going on, but I haven't heard any recommendation from the group on what's going to be the local policy. What are the relationships between the model neighborhood areas and the health centers? And the rural areas? It seems to me there has to be a combined relationship where if it happens in one area does it have to happen all over the state. I don't think there can be cooperation unless you involve the community groups since that's where the political power lies to change legislation. RMP is not reaching out into the communities, it's staying in universities and hospitals. That may be the policy of the Reagan administration who controls the university, but he'll be leaving soon and then you'll have to rely on the community. I think RMP needs to put more effort and interest into the community so it can really get some strength. There are community groups that do have money that is available to help strengthen the RMP and the CHP groups. You might get a lot if the Model Cities program will fund their allied school of health. This could happen in 10 or 12 more cities in California. If RMP will take that stand to do something constructive for the community groups. It's going to have to be done through local policy -- though it's you guys who will be making these decisions. We want to know from the community level "Are you going to be making that decision in an effort to help those groups?"

DR. ANDREWS: I will answer in part that not all areas have Model Cities components within them. Area II, for instance, does not, but we have been meeting with community groups to provide input into our planning activities.

AUDIENCE QUESTION; My next question is about the fragmentation since you have nine areas. All areas do not have Model Cities, but those areas that do have Model Cities can set a definite policy on how they would like to work with Model Cities groups. It would be statewide, so Model Cities would know what they can do and how they are going to do it. Today we have three of four Model Cities directors here. There has been no effort to try to get cooperation from these directors. What kind of input can they put into RMP in order to help since the RMP is asking for help? Or how can RMP help our community? This has to be discussed. As far as I'm concerned, I might as well be out playing football because I'm not getting anything out of it if we are not going to do something constructive for the entire community.

AUDIENCE COMMENT: My name is Al Parham, Model Cities Director, Berkeley. I'm not tuned in on this whole RMP thing as some Model Cities directors might be such as Henry Dishroom of Richmond and he is here. One thing that Mr. Lee from Oakland did put before you is the very serious and critical need for RMP to become involved in the community. I feel with this limited knowledge realizing that it is important for me that before Model Cities can get really involved as they would like to be involved, we are going to need assistance. For example, in Berkeley at this time, I could use assistance in terms of monies that could come to fund the health planning. One of the things we can do in our Model Cities Programs is to partially fund the position of a health planner with additional money coming from RMP. Then we begin to get into the community to do some of the things and move in the direction of change that I heard at least one gentleman talk about. I was really turned on from the standpoint of what Al was talking about because he was beginning to know where it's really at. I missed some of the earlier talks and I'm sorry about that. But we're going to begin to think seriously about the change, about how we use staffing, and also how we are going to be able to get representatives in the community. I think this is where it starts here. With Model Cites, we will be able to do a shared kind of thing and we look very seriously at that. I'm at a disadvantage because I don't know the principals. We're all important. The sister from Watts over there -- she's important. As they say, she's heavy. You people are important too. The reason I'm at a disadvantage is I don't known exactly who to go to. The assistance I've been getting has come through Virginia Greer who has been working in Northern California. One person trying to reach a whole bunch of people. I hope she doesn't mind my saying this, but if we are really concerned about getting out of the University into the community, then there shouldn't be one Virginia Greer, there should be more people funded to get out where the people are to begin to get some service. What good does it do to have one person who must serve a large number of people who only has time to talk. If we had enough people to begin to assist with providing enough information that can begin to improve services -- I understand that some words are dirty words and I don't want to use any of them now because I don't want to upset anybody -- but we could use assistance in knowing when people come into the community what you do need. I've already said what we could use. We are in the planning year of our Model Cities program. Some assistance will help us plan, even if it is a shared kind of funding arrangement. And we will move from that point to do those other things that we have not been able to do thus far because of the lack of staff. Any other Model Cities comments and it is very important that we talk about this, will have to come from a person who is involved more directly with the program, like Mr. Dishroom from Richmond. Model Cities doesn't plan to take this over, but I just think it is important.

DR. ANDREWS: Thank you very much. I think I'll let Mr. Paul Ward respond to this and then Dr. Smith if he would.

MR. WARD: There's no question but that we should be working closely with Model Cities and that we should be taking a very active part in the planning for the health needs that's going on in the overall plans that are being made up by the Model Cities. I will point out that we do have a strange situation that six of the Model Cities Programs and that's a majority of the programs in the state are in Area I. We have had only one person working with those six projects and that one person is highly overworked to try to handle what should go on from our point of view. In fact, one person in my opinion, could not handle the planning for one project, let alone for six. We did make application last month or last week I should say for funds to carry on Model Cities relationship as well as "b" agency relationship. This application will be site visited on December 7 and 8 and some decision will be made on the award after the first of the year. This does not mean that we should wait until then to try to do something. It does mean that we are going to be more limited in what we can do in this area and then we will, if the application is approved and funded.

MR. TORRIBIO: Neil, I think that Mr. Parham and Mr. Lee have spoken very eloquently of our need to work together. We have no choice because we are serving the same people. In fact, the people that the Model Cities program works with have a larger percentage of health problems than any other part of our society. We have only one Model Cities Program in Area IV, which is in Fresno. The director, James Aldridge, has been a member of our district committee since its inception. When he is unable to attend, he sends two community representatives as his delegates. We are just beginning in Fresno a preliminary plan involving one of Mr. Aldridge's staff in terms of a developmental possibility or feasibility study in one of the poor areas of Fresno with his staff. It will be a health planning project. We are trying to relate, but I sympathize with Area I with so many Model Cities programs.

DR. SHIMKIN: I just want to express my desire and pledge to do all we can with the Model Cities area. I wish we were sure we knew how to do it. We also carry the larger interest of CHP in our Area as well. Also, I wish to mildly retort to the fact that the University of California is supportive of these endeavors. The question is how far we can stretch without losing sight of the main task of educating the providers of health care. We have organized an outreach clinic in San Ysidero area and we plan another in southeast San Diego in the northern part of the county. Unfortunately many of these things are on the drawing board and not funded, but at least our heart is in the right place. We welcome opportunities to be of mutual assistance.

AUDIENCE QUESTION: I think we ought to dispense with the altruism, of extending ourselves, in Model Cities as an act of charity. We need the relationship to the Model Cities program. In one of our groups last night we talked about our increasing role in having an impact upon the health care delivery system. In the fact that in the primary care center, 80% of the demands of service fell into areas other than those which called for the specific skills of the physician for direct technical intervention. Many of these kinds of functions call for the kinds of manpower which we had not been accustomed to thinking of as the traditional health manpower which are related to the functions of some of these great other Federal agencies in addition to HEW, OEO, Labor, Housing, and I think it is in our interest as we begin to think of a delivery system which is going to have a substantial impact on the community to look to the one administrative structure which begins to pull together the whole range of human services and that is represented in the Model Cities area. It has developed in the lower socio-economic disadvantaged areas, but as in many other instances, we have to look to the extremes of illness in our communities to see things that are really applicable to the broad community as a whole. I think we find that in the Model Cities program. I'll be most interested when we hear from the regional representative of HEW, Dr. Smith as to the role that he sees for Model Cities in extending the RMP effort.

AUDIENCE COMMENT: Maybe I don't understand anything that went on this morning because I heard the man ask for a health educator he said he could use. The areas are all set up around universities and this is the kind of expertise you have. Now that was just so simple -- Ray Charles could see that and he is blind! Just so simple -- you could say I'll share a health educator with you in each area and then we'd go on about our business. He asked for that. Don't tell him to go back and write a proposal because we have RMP coordinators who are supposed to be experts at writing anything. The expert is supposed to know what to do. I don't tell him how to attack a community problem. I tell him there's one there and he better see to it that it gets on the way. It's time to get out of the great university settings to do something for the people. Don't keep talking about educating doctors. To do what? What are you going to educate them to do? What you have to do now is find a way for each area then you will have done something for these two days you've been here, find a way for each area to say you will give 4 hours of a health educator. That's as simple as it can be. In each area can you share a health educator? Can you do that?

Then I will understand what I came here for.

MR. LEE: As a director of one of the Model Cities programs in the Bay Area, we would like to request a meeting with Mr. Ward or somebody else to get a clear cut kind of definition of what's going to be done. We're talking about coordination and cooperation. In Oakland, RMP funded a West Oakland Health Center for $4,000 for a health planner. When we looked at it we said what will $4,000 do for a community that has 48,000 people in bad health so we give them $150,000. This type of cooperation is what we are talking about. You've got the expertise -- you've got the universities -- you've got all these hospitals that know what to do, just give us some cooperation and we'll get on with the business. You sit up there and waste 4 days when we could finish it in 30 minutes.

REMARKS

DR. MACK SMITH

DIRECTOR

HEW REGION II

DR. ANDREWS: Dr. Smith, you have heard the problem.

DR. SMITH: Thank you, Neil, for the opportunity to come here. Let me tell you some things I am and some things I am not. I regret now, after experiencing this morning session, that I was not here full-time. I must say that my reasons for accepting the invitation were somewhat varied. I'm not here to represent Dr. Margulies. I came here because I am new in the position I occupy, a scant ten days away from the bedside and instruction. My background is one of medical education, clinical investigation and health care administration. I became regional health director on October 19. I don't pretend to be an expert; I cannot even pretend to be completely knowledgeable, not only of all the programs we have responsibility for, but of all the problems these programs are directed toward. I would like to make a few remarks about my observations this morning and I will respond to that extent.

I began to be concerned about half way through that there had been no minority reports. That changed. Somewhat facetiously, I was concerned when I observed that all the men were up here and all the women down there. I'd like to express to you my intense personal interest and previous involvement in matters concerning RMP. As some of you from Area I know, the hospital of which I have been director has been involved in RMP programs in recent years. Of course, the program of RMP is much broader than my involvement. You've heard from Dr. Wilson about the mission of HSMHA which is the health care arm of the public health service, and I am sure he told you he sees the mission of HSMHA as providing the centers of expertise, but he did not tell you that it has centers of expertise. I think he recognizes that in becoming centers of expertise to help you with your programs will be a tough row to hoe. Now I'm impressed already in the short time I've been in the Region IX office that there are some experts there and I agree with someone's earlier comment that there aren't enough of them. One of the problems we have to grapple with in the regional office is far more complex than anything I have previously concerned myself with. My background in part is in biologic research. The problems in the laboratory are much, much simpler. You can define specific objectives or specific methods for solving them and things tend to line up in a row where you can plan appropriately.

I'd like to read one sentence of Dr. Wilson's which reflects on the difference between the kind of problem in the laboratory and one in the community. "By contrast, the HSMHA Center of expertise will be dealing with questions which are related to the action-oriented world of the community. It will be serving action-oriented people with problems whose solutions will pass the test of community reality. The problems here require delineating demands and needs, needs to programs, programs to resources." Believe me, that's a big order, but I assure you that all of us are expecting to achieve those missions.

I don't pretend to address myself to the specific relationship of Model Cities to RMP. It would be presumptious of me to do so in so short a time. One of the reasons why I came here was that I hoped to get some answers about the relationship between RMP and CHP. Someone said that the answer was yes; that didn't help me much. It is apparent to me that in your program you also considered some of the changes in the RMP legislation, particularly in regard to CHP.

I would like to address myself briefly to the significance of decentralization in carrying out program goals. To put it brutally and simply, decentralization is an effort to decentralize the bureaucracy so as to move a big share of decision making out of Washington to the community where it can be more responsive to needs and more sensitive to these needs. I don't think I need to tell you that government has become inefficent, confusing, frustrating, and it appears incapable of doing many of the things that its citizens expect it to do. It's probably fair to say that it isn't working very well.

John Fischer has remarked that this is government inefficiency in the one area that John Gardner, Walter Reuther, and William Buckley can agree upon. You are aware as I am of the events of the last twenty years; of the many new programs of the last five or six years. And for most of them monies -- never enough, but monies nevertheless. To each of these programs there were certain strings attached. The most important string perhaps was that these programs should develop comprehensive plans. Communities should have a plan. It could be seen by everyone where the program had planned. This all sounds very fine, but it didn't work out too well for a number of reasons. In the first place, the programs were piecemeal and were not related. The programs were administered by scores of different agencies and each agency had its own strings. Each agency required different kinds of reports, and there are a confusing variety of reports as

you know better than anyone. In fact, some areas were part of different comprehensive plans and the boundaries of one comprehensive plan overlapped the boundaries of another. The third problem with all these programs when money became available was that people looked around the communities and said "Whose plan?" There weren't any plans. There was a rush of people from all quarters and all sectors to get into the planning game. Having gotten there they had various degrees of competence at it. But they all looked around and the first thing they discovered was that there was no data to plan with. But the plans came in anyway. They were very imaginative, in fact, so imaginative that former HUD secretary Robert Weaver called them "great works of fiction." He implied that it had been expected by those who sent them in that the "nuts in Washington wouldn't catch them anyway." But the nuts in Washington did catch the works of fiction and they sent them back for rewrite after rewrite. Instead of taking three, four, five months to get a program through, it took three, four, five years. So this is the kind of problem we have had and the government's solution is decentralization. I could mention an example that came up recently and how complicated it can be. The governor of Kentucky developed an imaginative plan to rejuvenate the State of Kentucky. He wanted to build houses and schools, urban renewal, sewers and job training. He found out that housing had to go to HUD, schools and other education support had to go to HEW, five different agencies dealt with sewers and you were supposed to shop around to find the best deal. For job training you go to Labor or OEO or both. It turned out that all these agencies had field offices, but none of them were in Kentucky. For HUD he needed to go to Atlanta,for HEW to North Carolina, for Labor to Chicago. The Small Business Administration Office was in Philadelphia and the OEO field office for Kentucky was in Washington. As a result of the Federal System Streamlining Task Force (FAST), much of this is in the process of improving. The regional lines have been drawn so that lines coincide for HEW, HUD, OEO and the Department of Labor. It would now be possible for the Governor of Kentucky to go to one location to meet with people responsible for each of the programs mentioned.

Here are a couple of examples of tangible streamlining efforts. It used to be that if you wanted anurban renewal program you went to HUD for dollars. There were 286 separate items of information you were required to submit. One hundred and thirty-seven of these were determined to be useless and were eliminated resulting in an administrative savings of 800,000 pages per year of useless paper work. In Hew 14 reports were dropped and 18 others were revised, resulting in a savings of 51 man years of useless work saved on an annual basis. These are small instances of what the thrust of decentralization is all about.

As I said in the beginning my reasons for coming here were entirely selfish, I am in no position to contribute anything to your deliberations. I wanted to meet some of you; I wanted to learn a little bit about RMP and some of the programs related to it. The other reason was that I wanted you to know who I am. You know where our office is; it's our job to make this thing work. We'll do our best.

AUDIENCE COMMENT: Dr. Smith noticed that all the panelists were men. Did he also notice that all were white men?

DR. ANDREWS: When we started this conference, I told you that it was designed for the staff and advisory committee members to have an opportunity to get together and to learn what was going on in their own areas as well as the other eight areas throughout California Regional Medical Programs to gain insight into the projects that were ongoing. This, of course, has occurred, but over and above this we had an opportunity to hear from some of the other health related agencies and groups with concerns. I've asked Paul Ward to draw conclusions to the meeting to see that we have accomplished what we set out to do. Paul.

AUDIENCE COMMENT: Mr. Chairman, one thing I think there is another question that I think needs to be raised and I would like to give Mr. Ward a chance to speak to us because I'm relating it back to something he said before. I think there are two things that I am very concerned about. Now in this meeting and how things go on here, that is whenever we talk about the needs of communities immediately relates it to the fact that there was an application for additional funds to try to meet the needs of Model Cities in Area I. Now I've been over to Regional Medical Planning in Area I. There are I'm sure at least 20 people, professionally staffed people, at that office. But there is only one that is assigned to work with the six Model Cities agencies and the rest of them don't even know what we are about. Now I suggested that the 20 people and some reallocation of resources that there are already enough people there and you don't really need to go and get additional money to do the job. But now if you are going to make applications for additional funds it may be some consultation with us that needs the help and so our own capacity to help ourselves. It might even have been better. So what I say now is that working with the communities enough you are not taking advantage of the resources that are there and there's just an assumption that if somebody would give you additonal money that you would want to be able to do the job. Now I understand that the additional funds are supposed to provide an additonal person to relate to the six Model Cities in Area I. Now I don't believe two people can do it and so it's still out of the total complement of staff in the central office. We're getting crumbs and you can't serve the Model Cities with that much of your resources. So the first thing to talk about is a reallocation of

resources with another plan. Secondly, you have tremendous influence of the University of California and until the University of California which is doing a good job of protecting RMP or RMP protecting the University, I don't know how it goes, but until the University becomes relevant to the communities that it is presumably training people to serve and it is not until the University does that then there's still a lot of wasted resources so that I'm not one to speak in terms of additional funds that we can get from the Federal government. I'm talking about what we already have from the Federal government, we're talking about all that money that the University of California has and making that money and making those resources relevant to the communities you are supposed to be serving and we applauded; I've been to three teleconferences, three larges teleconferences recently and invariably the conclusion that everyone comes to is that until we get more help and different health manpower we will not be able to solve the health problems because of reduction of costs, the cost of medical service is absolutely necessary. Nevertheless we have not been able to get right down to a discussion at any of these conferences on how we get a meaningful School of Allied Health Sciences, for example, in our own area in the Bay Area, Number 1 and Number 2 to get over this matter of licensing that Mr. Ward mentioned before and I'll say this if you really mean it we have one step in terms of the first step, I guess you would call it a step in terms of the medical assistance that's been approved by the State of California. I say let's get on with that unless we really want to take on the medical profession and get different kinds of people authorized and trained to provide medical services and unless those services are going to be related to the communities they are supposed to serve, the people who need them really, then you're not doing us any good whatsoever. Now we've spent time up here and I think that for those of us who were invited that we have started to learn something about your language; however, you do not know anything about the language of the people back there in Richmond, California that need your services and I would say that your next meeting you have an invitation to come to Richmond. Now in terms of a plan, we have a plan and data, we have the availability of space, for example, we have a lot of people ready to cooperate to establish an allied health school in Richmond, California. So far we haven't gotten any spills or any assistance from the Federal government nor have we gotten much from RMP with the exception of one person who can't do it all. So I say that with all those people that Area I has, I believe you do not need additional help; you've got enough to start on the job if you will just reach out to the resources and certainly the University of California is wasting enough to do everything that Richmond needs and I suppose everything that most of these other communities need too.

PAUL WARD: There have been a number of points raised during these two days that need a lot of comment. In that regard, it certainly has been, I believe, a very good meeting. And as Henry and others have pointed out so well, we do have to get into the Model Cities program and other programs and do a good job of planning with them. I don't say this defensively because what's been said here today about Model Cities makes me very happy. It wasn't too long ago and I think this is a pretty good indication of progress, that we did make efforts to talk to the Model Cities programs. It was then that they pointed out to us that they had a great many problems and certainly their spectrum of problems is greater than ours. When they talk about these problems with their advisory committee , health was not necessarily on top. There were things like employment, training, housing, living conditions and other things, but health was not necessarily a top priority. But as we have seen these programs develop health has become more and more a priority within them. I think the time is ripe when we should try to rearrange some of our resources to begin to meet our obligations in this particular field. I have no doubt of this at all. I don't say this defensively and heaven knows, I can't speak for the universities, if anyone can, but I would point out that those people are in the program in projects for which we have been granted money. That money was granted for the specific purposes within those projects. Now apparently the money is going to become a little freer in the sense that RMP's programs begin to phase out we might be able to find new uses for these funds and to make these decisions ourselves. Let me point out that they won't be easy decisions to make because it is very, very difficult to phase an existing program out saying you are going to divert funds to another program. Because what was being done in those programs was needed in the first place or the money wouldn't have been granted. It's pretty rough sometimes to draw a list of priorities and say we've got to divert those funds away from existing projects into other projects. I think we can do it. I trust we can do it. If we don't we will have failed in the advantage and the responsibility that have been given to us, mainly, that is to make our own decisions. I think we are extremely fortunate in having Dr. Smith in the regional office as the health director. Dr. Smith is very aware of the needs of this program and how we should cooperate with other programs. We've always enjoyed a good relationship with the regional office and I'm sure that relationship will go on. We are more fortunate I think than most other portions of the United States where these harmonious relationships with the regional office have not taken place.

When Dr. Wilson was here yesterday, I felt a cringe of guilt although I think I was completely innocent. He said you put forth your best Sunday suit in describing the presentations. I hadn't noticed the agenda that morning, but it fitted so perfectly with the national priorities, as if someone had sat down to devise a program to impress a representative of the Federal government.

He couldn't have done a better job. I had nothing to do with that agenda after it was put together, not even then did I realize what had happened. It was an excellent set of presentations, it was an emphasis on meeting the health care needs of the poor, it was aimed at thosespecially marked groups that pertain to the priorities set forth and I'm sure as he left here he said he was very, very impressed with what had happened. I think the change has come through loud and clear that we are trying to change our direction and emphasis from one of developing quality on top of quality to one of taking a look at the health care needs in the less fortunate communities and seeing if we can't do something about those health care needs. I say that because we are at somewhat of a strange situation now. They give us the ability to make our own decisions about what we want to do within the confines of the law and the legal restrictions on that money. We have the ability to turn around and face the national priorities set forth by HEW and to meet them or we can say to hell with HEW priorities and not do anything about them. But I don't think circumstances would allow us to do that as witnessed this morning, but we could do it if we wanted to. If the site visit review team came out and said "how did you spend your money?" and we said "we spent it this way" the site review team would then say "that isn't necessarily the way we had in mind for you to spend it." And we would say, "but you gave us the authority to spend it the way we wanted to that we thought agrees with our authorities." You noticed that Wilson said that he wanted to be the last one to tell us how we should spend our money. I raise that, not because I have any concern about what the site visit team would do, whether it would recommend that we get less money next year and less after that or more money next year and so forth. What we must do is to take a look at what's occurring and make our decision based on that. I want to bring up one thing that wasn't mentioned during this meeting. Dr. Wilson pointed out very clearly that the Bureau of the Budget has said there is going to be level funding for the next three years. He didn't actually say three years, but the projections for the next three years give RMP a very slight increase. I'm not condemning the Bureau of the Budget, but it isn't God. We have a tendency to overlook that sometimes. There are a lot of forces at play. For example, the Senate raised the RMP appropriation by $18.3 million. The Bureau of the Budget asked for this to be knocked out by the conference committee, but we did get a pretty good increase. Sure the Bureau of the Budget can keep us from spending that money, but there are other things involved besides the Congress. To quote Sylvia Porter, a national health insurance program is inevitable. It is going to be the main topic of discussion during the next Congress. No one disagrees that national health insurance is coming -- coming more quickly than the Bureau of the Budget would like to see. When National Health Insurance does come it will make our role more exciting and dramatic than we dream of. It means, regardless of what people say, that there will be more funds in Regional Medical Programs. Maybe RMP hasn't revolutionized the world, but it's all they have. They must use what they have to try to meet the needs. People may say its illogical to have national health insurance before building up the system of providing the means for delivering care, but in the United States, it doesn't function on the basis of logic. It functions on the basis of what the people want. Let me cite an example to show that the average person does not realize that medical care is poorly organized until he must wait in a doctor's office or travel a long distance to receive help. The average citizen doesn't think about the organization for the delivery of health care every day of his life. What does he think about, every time he feels a pain? "How do I pay for this illness that's coming on me?" He just hopes that he has coverage for it and he hopes it's not something that will tie him up for $25 or $30,000. When you have that kind of a situation you have a conscious and a subconscious friend on the part of people toward seeking some kind of protection against the economic involvement. That's why in California we had Proposition 1 on the ballot. The people voted Proposition 1 down, but it would have increased our capacity to provide manpower. They voted it down for many complex reasons other than not understanding the complex health care shortage. At the same time a national poll showed that 72% of the people supported national health insurance. When that many people support a program, Congress will vote that kind of program. If you look at the money that's been put up on the providers side to help us ease into that kind of program, you will see that the Federal government has put up less resources in the last three years for the development of health care capabilities than it did before we had these problems. There is no indication that Congress or the Administration will put money into the development of manpower for the easing of health care problems until we face a greater crisis than exists now. The way to create a greater crisis than exists now is with the advent of more purchasing power for medical care benefits. This is the trend we will take. Logically and morally then, the RMP has the responsibility of aiding these efforts in that direction. If the HMO provision passes we have the obligation to at last push this development as far as we can with our planning abilities. We must be even bolder and create management capabilities in health care areas in concert with the CHP. This is a complicated subject, but management capabilities in dealing with several facilities and providers in one catchment area making sure of maximum use from each facility. In fact, deciding which cases should be outpatient, who should have what kind of services in each facility with some kind of control over the percentage of utilization and all the rest. This is a tremendous job. I should mention that we are on the road toward franchising of facilities of rate studies as dirty as that word may be, but it is inevitable. We must be thinking in those terms and making our plans accordingly. It won't be easy. I hope we can accept these

responsiblities and I hope we can come up with wise decisions. I think we, with CHP have the ability to make these decisions better than anyone else. If we're not perfect, we are all they have. With that in mind, I hope we can start a series of discussionsat the local level built around these particular concepts and I think if we do we will see new life, new hope come into the program. I think you will see rough times, but it will all be worth it.

DR. ANDREWS: With that, the conference is ended. Thank you for coming.